505 10/26/87 447-A-3 HE23.3008:M52

[redacted]

ORIGINAL

MENTAL HEALTH SERVICES FOR THE ELDERLY:
INSTRUCTOR'S MANUAL

Edited by

James R. Moon
Joan Gleason-Manlove

Department of Aging and Mental Health
Florida Mental Health Institute
University of South Florida
Tampa, Florida 33612

This project was supported, in part, by award number 90AT0174/01, from the Administration on Aging, Office of Human Development Services, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely, their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

TABLE OF CONTENTS

Page
Introduction i

Social History v

Notes to Chapters

1. Demography of Aging 1

2. Normal Aging 37

3. Mental Health Services for the Elderly 51

4. Legal Issues in Mental Health and Victimization 83

5. Deficits and Losses of Aging 107

6. Communicating with the Elderly 143

7. Social Support Systems 169

8. Psychopathology I: An Overview of Psychopathology and the Elderly ..181

9. Psychopathology II: A Review of Selected Disorders 233

10. Substance Use Disorders 247

11. Psychotropic Medications 401

12. Assessment: Methods and Process 417

13. Major Assessment Areas: Activities of Daily Living, Social Skills, Mental Health Status, and Physical Health and Function 425

14. Assessment: The Polyproblemed Client and Placement 497

INTRODUCTION

edited by

James R. Moon

Joan Gleason-Manlove

This Instructor's Manual is designed to accompany Mental Health Services for the Elderly: A Training Manual, edited by Diane W. Burr, Joan Gleason-Manlove, James R. Moon, and Amy B. Powell. The Instructor's Manual contains additional background readings that supplement the main text, notes to instructors, templates for viewgraphs (overhead slides), and pre/post tests and answer keys.

The materials found in this Instructor's Manual represent the actual notes, aids, etc. prepared and used by instructors for each section. Some sections' original text is more self-explanatory than others, hence, there are some variations in the comprehensiveness and quantity of additional teaching aids found in this manual. In general, the instructor should be thoroughly familiar with the materials in the Instructor's Manual before attempting to teach.

The suggested order of sections and the minimum number of sessions/hours devoted to each section is presented in Table 1. The suggested format for teaching these sections was developed by experimenting with several different methods. Thus, our suggestions stem from field tests of this curriculum.

This manual is divided into major sections which represent the various course topics within the entire curriculum. Each major section is further divided into 6 subsections as follows:

Subsection	Topic
1	Course Outline
2	Text
3	References
4	Notes to Instructors
5	Teaching Aids
6	Pre/Post Test and Answer Key

SUGGESTED TRAINING FORMAT

This training manual has been designed in such a way that the entire course can be taught in eighteen two hour sessions. Most of the topics can be covered in one session. The two hour session format includes time for a fifteen minute break and also allows ample time for group discussion. It has been found that the teaching process is greatly facilitated when open discussion is encouraged. This is especially true for adults who work in a field related to the study topic. They bring a wealth of practical knowledge into the classroom situation.

CHAPTER TITLE	HOURS	SESSIONS
1. Demographics of Aging	2 HOURS	1 SESSION
2. Normal Aging	2 HOURS	1 SESSION
3. Mental Health Services	2 HOURS	1 SESSION
4. Legal Issues & Victimization	2 HOURS	1 SESSION
5. Deficits and Losses of Aging	2 HOURS	1 SESSION
6. Communicating with the Elderly	2 HOURS	1 SESSION
7. Social Support Systems	2 HOURS	1 SESSION
8. Psychopathology I:	4 HOURS	2 SESSIONS
*Historical Overview	2 HOURS	1 SESSION
*Using the DSM III	2 HOURS	1 SESSION
9. Psychopathology II:	8 HOURS	4 SESSIONS
*O.B.D./ Dementia/ Cognitive Dysfunction	2 HOURS	1 SESSION
*Schizophrenia	2 HOURS	1 SESSION
*Depression/ Affective Disorders & Grief Reactions	2 HOURS	1 SESSION
*Anxiety Disorders & Personality Disorders	2 HOURS	1 SESSION
10. Substance Use Disorders and the Elderly	2 HOURS	1 SESSION
11. Psychotropic Medications	2 HOURS	1 SESSION
12. Assessment: Methods and Process	2 HOURS	1 SESSION
13. Major Assessment Areas	2 HOURS	1 SESSION
14. The Polyproblemed Client	2 HOURS	1 SESSION
	36 HOURS	18 SESSIONS

This is a recommended format. It can be adjusted to meet the needs of different groups.

In the first session, the major task is to introduce the students to the text, the rationale for the training, and to each other. Explain how the course will be taught and what your expectations are for the class members. Ask what their goals and expectations are. Urge the students to read each section before you meet for class. This will facilitate understanding and foster group discussion. It is important that you leave time for the class members to become acquainted with each other during the session.

In your materials is a social history form. It has proven very helpful for past classes to use this. Have the students take a former client, or an older person who is not a client, and complete the information requested on the form. Ask them to provide as much detail as possible. Remind them to give their "client" a fictitious name, and to keep the principles of client confidentiality in mind at all times. This case study is for class use only. Once completed, have the students refer to it and update it as they progress through the course and acquire more knowledge about aging and about mental health.

In each section of the Instructor's Manual, you will find, in addition to these "notes," reprints, graphs, worksheets, and diagrams that you can reproduce and pass on to your students if you wish. In addition, each chapter has a quiz. This can be used as a study guide, as a pre/post test of acquired knowledge, or simply as a quiz at the end of each chapter. The tests contain the information that we felt the students should have gained when they complete the chapter. You might wish to emphasize these points in your lecture.

SOCIAL HISTORY

CLIENT: Case, Ima Modal **ADMISSION DATE:** 10/11/84

DOB: 5/26/19

ADMISSION DIAGNOSIS: Schizophrenia, Chronic Undifferentiated Type with depressive features.

I. SOCIAL SUPPORT

Client is a 65-year-old white widow who was born and raised in Ohio. She moved to Florida in 1956. The client reports several generally unsuccessful marriages. She has 3 children with whom she has very limited contacts. The client reports a very limited social support network. She is currently living in a boarding home facility.

II. ECONOMIC & EDUCATION

The client dropped out of the 11th grade. She reports making average grades. The client has not engaged in steady employment of any kind. She worked mainly between marriages. The client receives $250.00/month income from Social Security. The client has no medical/hospitalization insurance coverage.

III. LEGAL

The client is voluntary competent. There are no legal problems.

IV. SELF-DEFINED

The client states that she has no problems and wants to be discharged as soon as possible. The client understands that she will probably be in the program for about 17 weeks.

V. PHYSICAL HEALTH

The admission physical examination, revealed a reported history of several medical problems:

1. Diabetes Mellitus, Insulin dependent.
2. Hypothyroidism
3. Chronic obstructive pulmonary disease (COPD).

VI. MEDICATIONS

NPH Insulin 25U. @ breakfast - daily
Synthyroid 0.15mg - daily
Theo-dur 200mg - BID
Navane 10mg - BID
Sinequan 50mg - H.S.
Cogentin 2mg - BID

VII. MENTAL HEALTH

The client has a long history of psychiatric problems. The client can recall at least 5 previous psychiatric hospitalizations dating back to the early 1940's. The client was usually hospitalized for about 10 months. The most recent hospitalization occurred subsequent to the client's refusing to take appropriate care of herself. She was taken to the crisis center and from there was transferred to the county hospital. The client denies homicidal/suicidal ideations and drug/alcohol abuse. The client states that she sometimes hears voices, especially after she has not taken her medications for some time. The client can identify no clear precipitating events except that she "just has nervous breakdowns."

VIII. SOCIAL LEISURE

The client reports no close friends. She says that her major social-leisure activity is television-viewing.

IX. SKILL DEFICITS AND PLACEMENT

The client has marginal self-care skills. Her communication skills are inadequate as are her skills in productivity using her unstructured time. The client will need to enter all of the skills-building treatments, and by the time of her discharge 17 weeks from now she should be able to live more independently in a boarding home or other Adult Congregate Living Facility (ACLF).

SOCIAL HISTORY

CLIENT: **ADMISSION DATE:**

DOB:

ADMISSION DIAGNOSIS:

I. **SOCIAL SUPPORT**

II. **ECONOMIC & EDUCATION**

BLANK PAGE

III. LEGAL

IV. SELF-DEFINED

V. PHYSICAL HEALTH

VI. MEDICATIONS

BLANK PAGE

VII. MENTAL HEALTH

VIII. SOCIAL LEISURE

IX. SKILL DEFICITS AND PLACEMENT

The written text gives a clear picture of the older population in the U.S. and in Florida. "Old" is a relative term. This is a good spot for a short group discussion about who is old and when a person becomes old.

It will probably be best to conduct your lecture while you and the students review the demographic charts and tables together. Information about the older population in your local counties can be obtained from the Dept. of Health and Rehabilitative Services, Aging and Adult Services, State of Florida. If you have an overhead projector available you might find that transferring some of the population statistics to transparencies will help maintain your students' attention and interest.

To put the "greying of America" into perspective for your students, let them know that: the average lifetime for an individual in ancient Rome was between twenty and thirty years of age. This remained the same through the medieval times. In the U.S., by the mid 1800's, life expectancy had risen to forty years of age with another nine-year increase by 1900. Within the next sixty years we added two decades to the life expectancy in the U.S.

Students should be aware that these gains are due much more to declines in the infant and child mortality rates and a declining birth rate, than anything that adults are doing to extend their own lives. Individual efforts do not alter actuarial charts.

Life expectancy and life span are two phrases that are often used interchangeably. They should not be. Life expectancy is the number of years a person can be expected to live from their date of birth. Life expectancy figures are arrived at statistically and can be altered by changing social conditions. It can vary for sub-groups within a population. Life expectancy is sensitive to public health practices and their acceptance by the population. Sex, socio-economic status, and occupation are also important variables that must be taken into consideration whenever a discussion of life expectancy is undertaken.

Life span, on the other hand, is presumed to be determined by a fixed "program" in the genes of body cells - specifically, by a code in the DNA of the genes. Life span appears to be fixed from species to species. In humans it is estimated to be at about 100 years. Life span is not variable by any external factor. It does not change between races or nationalities. It has remained the same in the U.S. for over 140 years.

A major reason for paying attention to the demographics of a population is to spot trends so that service providers can project future needs and plan for them. As the population of an area changes, service providers and policy makers must be able to decide what shifts should be made in types of services offered and the size of the population that will require them. Short term population changes must be paid attention to. In some areas of Florida, planners for nutrition sites have to keep in mind the date of Easter week. The census at their site drops dramatically after Easter, when many seasonal residents return to their northern homes.

Review the terminology used in the text with your students.

1. Older population --- 55 and up
2. Young old --- 55 - 64
3. Elderly --- 65 and above
4. Aged --- 75 and above
5. Old-old --- 85 and above

A possible point for discussion is that the old-old is the fastest growing age group in our population. The network on aging faces a constantly expanding caseload. The incidence of dementia rises to 20% for the over 85 group (it is less than 5% for all elderly).

Migration has an enormous impact on service planning for the elderly. In 1980, 25% of all people over 60 who moved across state lines came to Florida. Research is being conducted to see if the needs of these migrants are different from the needs of elderly natives.

BLANK PAGE

Viewgraph #1 for Overhead Projection

POPULATION STATISTICS

Age Group and Percent of Total Population

1980 Census

	55-64[1]	65-74	75-84	85 +	Total
U.S. Pop. (Mill's)	21.7	15.6	7.7	2.2	47.2
Per Cent	9.6%	6.9%	3.4%	1.0%	20.9%
Fla. Pop. (Thous's)	565	1,059	501	117	2,242
	5.8%	10.8%	5.3%	1.2%	23.1%
District (Thous's)	60.9	108.8	53.2	13.2	236.1
	5.1%	9.2%	4.5%	1.1%	19.9%

[1] 60 to 64 years of age group for Florida and District 6.

BLANK PAGE

Viewgraph #2 for Overhead Projection

POPULATION TRENDS - PAST, PRESENT AND FUTURE PROJECTIONS

A. Older Population in the U.S.

Age Group in Millions and Percent of Total U. S. Population

Year	55 to 64		85 & Above		Total	
1960	15.6	8.7%	0.9	0.5%	32.1	17.9%
1980	21.7	9.6%	2.2	1.0%	47.2	20.9%
2000	23.8	8.9%	5.1	1.9%	58.8	22.0%

B. Older Population in Florida

Age Group in Thousands and Percent of Florida Population

Year	60 to 64		85 & Above		Total	
1980	565	5.8%	117	1.2%	2,242	23.1%
1985	652	5.8%	154	1.4%	2,674	24.0%
1990	679	5.4%	203	1.6%	3,031	24.2%
2000	727	5.1%	326	2.3%	3,493	24.7%

BLANK PAGE

Viewgraph #3 for Overhead Projection

CHARACTERISTICS OF FLORIDA ELDERLY

Florida Population by Age and Sex

	Female	Male	M / 100 F
All Ages	52%	48%	92
59 Years Old & Younger	51%	49%	97
60-64 Years Old	55%	45%	80
65-69 Years Old	55%	45%	81
70-74 Years Old	56%	44%	79
75-79 Years Old	57%	43%	75
80-84 Years Old	59%	41%	68
85 Years Old & Older	63%	37%	58

BLANK PAGE

Viewgraph #4 for Overhead Projection

CHARACTERISTICS OF FLORIDA ELDERLY

Median Household Income (1979) by Age of Householder

All Households	$17,280
Age 35 to 44	20,885
Age 45 to 54	22,454
Age 55 to 64	18,942
Age 65 and older	12,713
Age 65 and older, unrelated males	5,824
Age 65 and older, unrelated females	4,953

BLANK PAGE

Viewgraph #5 for Overhead Projection

CHARACTERISTICS OF FLORIDA ELDERLY

Social Status

Age	60-74	75-84	85+
Married, Living with Spouse	70.3%	49.8%	26.7%
Living Alone	18.1%	30.8%	30.6%
Living with Relative	4.1%	9.0%	21.3%
Living with Non-relative	2.3%	4.7%	13.2%
Other	5.2%	5.7%	8.2%

Nursing Homes, ACLF's, Foster Homes, State Institutions, Homes for the Aged, V.A. Hospitals, etc.

BLANK PAGE

Viewgraph #6 for Overhead Projection

CHARACTERISTICS OF FLORIDA ELDERLY

Services for the Elderly Florida Population in Florida
For Fiscal Year 1982-1983 Except As Noted

Type of Service (No. of Clients)	% of Elderly (60 & older)	Expenditures (Cost/Client)
Older Americans Act (AAA) 274,635	11.2%	$53,484,467 $195
Social Services (District HRS) 19,704	0.8%	5,009,581 $254
Community Care for Elderly (AAA) 21,177	0.9%	16,414,162 $775
Home Care for the Elderly (HRS) 3.383	0.1%	2,975,771 $880
Adult Foster Care (HRS) 1,175	0.05%	622,044 $529
ACLF; All Adults (HRS) 5,294	0.2%	2,806,994 $530
Nursing Homes: Medicaid 28,613	1.2%	197,560,769 $6,905
State Hospitals (83-84) 2,384	0.8%	43,068,000 $18,065
Medicaid other than Nursing Homes 98,365	4.0%	113,839,231 $1,157

BLANK PAGE

Viewgraph #7 for Overhead Projection

MENTAL HEALTH SERVICES FOR THE ELDERLY

Type of Service (No. of Clients)	% of Elderly (60 & older)	Expenditures (Cost/Client)
Nursing Homes: Medicaid 28,613	1.2%	197,560,769 $6,905
Medicaid other than Nursing Homes 98,365	4.0%	113,839,231 $1,157
Older Americans Act (AAA) 274,635	11.2%	53,484,467 $195
State Hospitals (83-84) 2,384	0.8%	43,068,000 $18,065
Community Mental Health Services 73,060	2.3%	18,478,624 $253
Geriatric Res. & Treatment (GRTS) 500 (Est.)	0.01%	8,000,000 $16,000
ACLF; All Adults (HRS) 5,294	0.2%	2,806,994 $530
Adult Foster Care (HRS) 1,175	0.05%	622,044 $529

BLANK PAGE

DEMOGRAPHY

Name: ______________________________ Date: ________________

CIRCLE THE CORRECT ANSWER.

1. In the United States, over the past one hundred forty years, the life span has:

   a. increased
   b. remained the same
   c. decreased

2. The fastest growing age group of elderly in the U.S. is:

   a. 75-84
   b. 85+ above
   c. 60-74

3. Each person is an individual differing from all others. As people age the amount of difference among people tends to:

   a. become less
   b. remain the same
   c. increase

4. As a percent of the total U.S. population, the number of elderly are expected to:

   a. become less
   b. remain the same
   c. increase

5. In Florida, the population age trends are ______________________ those of the United States.

   a. about the same as
   b. much more than
   c. much less than

6. The best criterion to apply in determing what is an appropriate activity for an elderly person is:

   a. age
   b. physical condition
   c. attitude

7. The majority of elderly under the age of 75 live with:

   a. their children
   b. friends
   c. spouse

8. In the United States, as they grow older women tend to:

   a. outnumber men
   b. remain about the same number as men, 50-50
   c. become fewer than men

9. In Florida the largest dollar amount of support for the elderly goes to:

   a. home health care
   b. state hospitals
   c. nursing homes

10. The largest number of Florida elderly are served by:

   a. Medicaid
   b. State-funded services
   c. Area Agencies on Aging

Demography

1. b
2. b
3. c
4. c
5. a
6. c
7. c
8. a
9. c
10. c

BLANK PAGE

As mental health ideologies have changed, the system serves a smaller proportion of older persons than in earlier decades. This paper discusses likely future changes in the characteristics of older persons and of mental health professionals and makes recommendations for changes in the system.

The Mental Health System and the Future Aged[1]

Robert L. Kahn, PhD[2]

Prediction of the future, in considering the mental health needs of the aged, requires an understanding of the past. Accordingly, we will first consider the patterns of mental health care of the aged in the first half of this century and then contrast it with more recent changes. It is our contention that such an analysis discloses a clear-cut pattern of negative age bias, that some of the factors underlying this bias will remain, while others will have altered significantly by the year 2000, and, finally, that it is then possible to make predictions both about what *will* happen and what *should* happen.

The early 1900s were characterized by the great buildup of mental hospitals, particularly those operated by states and counties. In 1904 there were 150,151 persons resident in mental hospitals in the United States, while the total was 633,504 in the peak year of 1955 (Willner, 1974). During this period there was a systematic age bias, with older persons being disproportionately hospitalized.

Fig. 1 shows first admission rates per 100,000 persons of each age group in the state of New York from 1909-1911 to 1949-1951. At every decade there was a consistent age gradient: the older the age, the higher the rate of admission. Although the rates for other age groups remained fairly constant over this 40-year period, remaining between 50 and 150 per 100,000, the aged not only had an initially much higher rate, but the rate continued to rise, more than doubling the 1909-1911 rate by 1949-1951, and going from around 200 to approximately 435 per 100,000.

After World War II there was a dramatic alteration in our conceptions and patterns of mental health care. With such milestones as the establishment of the National Institute of Mental Health in 1948, the organization of the Joint Commission on Mental Illness and Health in 1955, and the passage of the Community Mental Health Centers Act of 1963, there was a more active and optimistic attitude toward mental illness, characterized by radically reduc-

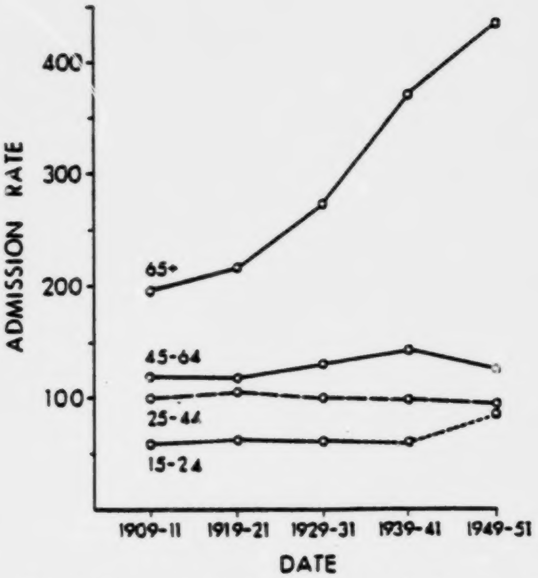


Fig. 1. First admissions to all hospitals for mental disease in New York State, 1910-1950: Rates per 100,000 population in each age group (derived from Malzberg, 1967).

---

[1] With the assistance of Sanford Finkel, MD, Raymond Launer, Jay Magaziner, and Kenneth Sakauye, MD.

[2] Associate Professor, Dept. of Psychiatry, and Committee on Human Development, Dept. of Behavioral Sciences, Univ. of Chicago, Chicago 60637.

ing the resident mental hospital population and developing such other services as psychiatric units in general hospitals, outpatient services of all kinds, and the vaunted community mental health centers.

These developments did result in drastically changed patterns of use of psychiatric facilities, but patterns which varied strikingly according to age. In Fig. 2 the percentage of change for each age group is shown in the first admission rates to all state and county mental hospitals in the United States between 1946 and 1972. Once more there is an age gradient but now it is diametrically opposite to that shown for the earlier years of this century. In the past 25 years there has been an enormous increase in the first admission rate for the very young, 97%, with the amount of change progressively decreasing with age, being unchanged for the 45-54 year group, and then showing a great *decrease* for the older patients, going down over 71% for those aged 65 and over.

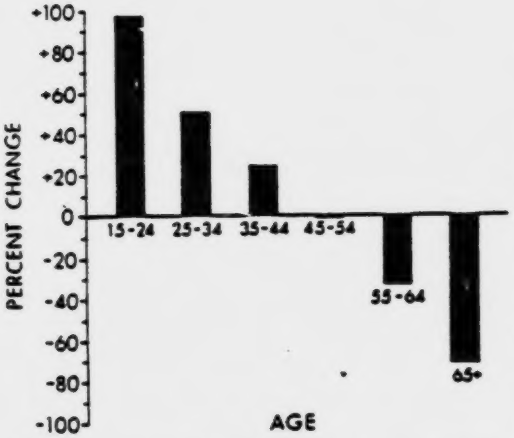


Fig. 2. Percentage of change between 1946 and 1972 for each age group in rate of first admissions per 100,000 population to state and county mental hospitals (USA) (derived from Kramer, 1973a).

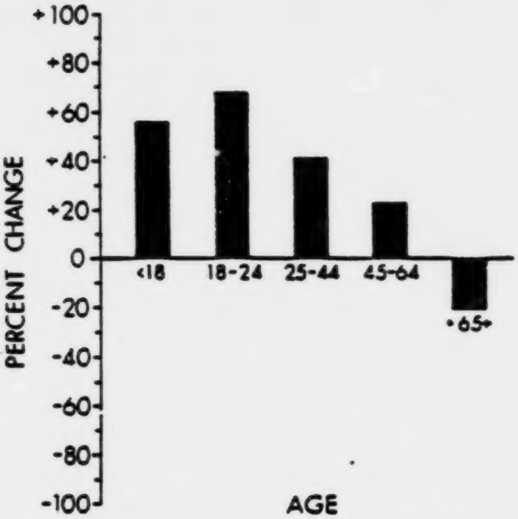


Fig. 3. Percentage of change between 1966 and 1971 for each age group in rate of patient care episodes per 100,000 population for all psychiatric services (USA) (derived from Redick, 1973).

These figures are based on first admissions to mental hospitals, but a similar trend is found when examining patient care episodes in all psychiatric services. Patient care episodes are defined as the number of residents or enrolled patients in all types of psychiatric facilities at the beginning of the year plus the total additions to these facilities during the year. Comparing the years 1966 and 1971, with all the new facilities and services available, there was an increase of 37% in patient care episodes for the total population (Redick, 1973). Again, as shown in Fig. 3, there is an enormous age differential, and a consistent gradient, with younger persons showing the largest increases (as much as 67.5% for those 18-24 years of age), with lesser increases for successively older age groups, and with those aged 65 and over showing an actual *decrease* of almost 22%.

Rather than helping older persons, the great mental health revolution has only led to their dropping out of the psychiatric system. Certainly the new programs have not helped the aged. If we look, for example, at psychiatric units in general hospitals, from 1966 to 1971 there was a 45% reduction in the number of patient care episodes for the aged. In Community Mental Health Centers, in 1971 the aged represented only 7% of inpatient service, and only 3% of their outpatient cases. Of all other outpatient services, the aged were only 2% (Kramer, 1973a).

To the question of what has happened to the aged mental health dropouts, obviously much of the answer can be found in the data on nursing homes. In an analysis by Redick (1974) of changes in the utilization of psychiatric services by the aged mentally ill during the decade 1960-1970, he concludes that there is an "emerging custodialism" in which the aged are now being displaced to nursing homes. Showing an incredible increase from 554,000 residents in 1963 to 1,098,500 10 years later, and with a current bed capacity of over 1,200,000, the nursing homes have replaced the state and county hospitals as the custodial warehouses. This has led to an increase in the total proportions of persons aged 65+ who are institutionalized, with the proportion rising from 4% to 5% from 1960 to 1970.

In 1963 almost two-fifths of the aged who were diagnosed as mentally ill and who were in long-term care institutions were to be found in state and county mental hospitals, while 53% were in nursing homes and personal care homes. These proportions changed drastically in 1969, when 75% of the aged mentally ill were in nursing homes.

It is obvious that the elderly are being neglected by the mental health establishment. The explanation for this unfortunate state of affairs is undoubtedly complex. It is a common stereotype among clinical gerontologists that other mental health professionals avoid the aged because of psychological problems such as ". . . unresolved conflict with parental images and the need to deny our own mortality . . ." (Lawton & Gottesman, 1974). Although there may well be some degree of psychological selectivity in determining which professionals become gerontologists, there is no *a priori* basis for presuming that this group are more mentally healthy than other professionals, or that they have fewer unresolved conflicts over growing old. It could just as well be hypothesized that those who work with the elderly may have *excessive* unresolved parental conflicts, or excessive problems in confronting their own mortality. In any case, such simplistic psychological explanations would damn the aged to continued neglect so long as human beings have parents and so long as human beings die.

Nor can the data be interpreted mechanically in terms of administrative considerations or idiosyncratic financial status of the aged, although these are obviously contributory factors. It is not a situation of the aged against the world. There is a consistent age gradient over the entire life-span which must be accounted for, in which the aged, defined here as those who are 65 and over, are simply the extreme of a continuum.

In contrast to the views just mentioned, the patterns of psychiatric care of the aged can be better explained on the basis of a reciprocal aversiveness between the mental health establishment and older persons, based on the interaction of such factors as mental health ideology, social class characteristics, and considerations of age appropriateness.

Ideological Factors

Over the past two centuries in this country, there have been several clear ideological movements and patterns with regard to mental health. Originally the mental hospitals were established as part of a great humanitarian movement to provide treatment for the mentally ill instead of merely depositing them in prisons or poorhouses. In the 19th century the advocates of "moral treatment" endeavored to improve the quality of care in the mental hospitals: but with the increasing flow of lower class immigrants as patients, the hospitals became very custodial in their orientation, relying heavily on the use of restraints (Grob, 1966). In the 20th century the mental hospital continued to deteriorate until our World War II experiences and some new developments in England (e.g., Carse, Panton, & Watt, 1958; Macmillan, 1958) contributed to a reconceptualization of our mental health ideology.

The prevailing practices in hospital treatment were so bad that even politicians could make the obvious criticisms, as evident in President Kennedy's message to Congress on "Mental Illness and Mental Retardation" in 1963:

> . . . (these new programs) have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they were out of sight and forgotten.

The mental health ideology that had led to these conditions, often implicit in the actions of society and of professionals, can be summed up in the concept of "custodialism" (Greenblatt, Levinson, & Williams, 1957; Greenblatt, York, & Brown, 1955; Stanton & Schwartz, 1954). Gilbert and Levinson (1956) actually developed a Custodial Mental Illness Ideology Scale to measure the extent of this ideology which they contrasted with "humanism." The components of an ideology can be found in attitudes toward the nature, causes, and treatment of mental illness, including hospital aims and policies. The principal components of custodialism are a basically negative or therapeutically pessimistic approach to the mentally ill; patients are perceived as being categorically different from normal people; patients are perceived as unpredictable and dangerous, requiring care in a highly controlled setting; the setting is concerned mainly with detention and safekeeping; and the institution is conceived as a rigid status hierarchy with lines of communication following the chain of authority, and with the patient occupying the lowest status position in the hierarchy.

Opposition to custodialism took many forms, both inside and outside the institution, with some who challenged the role of the institution itself. Much of the change within the institution was embodied in the concept of the "therapeutic community" which originated in Britain (Jones, 1953; Main, 1946). Taking a more optimistic view of mental illness, the proponents of the therapeutic community believed that much pathology was induced by the institution itself which compelled the patient to learn and act the "sick role." To prevent such a development they advocated democratizing the hospital, flattening the heirarchy, opening up two-way communication channels, and utilizing the skills of the total personnel of the institution, with special emphasis on the expanded role of the patient.

The new philosophy was indeed accompanied by many changes,[3] with meetings of staff and patients on psychiatric wards, by establishing "open" hospitals by unlocking the doors, by increasing personnel, and by accelerating patient turnover. But the application of the ideological shifts were uneven in their effect on different age groups. There seems to be a consistent relationship between custodialism and age. Prior to World War II, with mental illness regarded as a stigma, with custodialism as the dominant philosophy, and with the mental hospital serving primarily to extrude the mentally ill from society, older persons were more frequently hospitalized than younger persons. With the change in orientation after the war, the age gradient was reversed. For the young, the changed ideology represented new possibilities for treatment. For the aged, custodialism continued to prevail but with one difference—earlier the aged were treated custodially in mental hospitals (despite the presence of psychiatrically-trained personnel); now they are treated custodially in nursing homes (without any pretense of psychiatric service).

Part of the great displacement of the mentally ill aged from the state hospitals to nursing homes has resulted from a mechanical adherence to slogans, such as "alternatives to hospitalization." Based on the principle that state hospitals are unsuitable settings for the elderly, programs have been developed to find alternatives; but this usually means the use of nursing homes, without the realization that nursing homes are even more custodial in their care than the hospitals they are meant to replace (Epstein & Simon, 1968). The confusion of slogan and substance is, of course, common in contemporary mental health trends. The shift from the hospital to the community, for example, may simply represent a changed location but the same old philosophy (Polak & Jones, 1973).

Custodialism as a Self-Fulfilling Prophecy

In part, the age biases in mental health treatment demonstrated above are a direct consequence of the policy of custodialism. The negative attitudes associated with custodialism resulted in the accumulation of chronic patients, predominantly schizophrenics, who were hospitalized at an early age and then remained institutionalized, commonly for life. Such persons thus constituted an aging resident population for whom custodialism had been a self-fulfilling prophecy, teaching them the "sick role," isolating them from their families and from normal community activities, and making them incapable of living without extensive protective care. Custodialism applied to the young eventually created a cohort of older persons who required it or could be moved out of the mental hospital only by heroic efforts. These patients were galling to the hospital staffs, taking up so much time, space, and money and with such little benefit. On reaching age 65 these patients were routinely shifted to the "geriatric" ward, and their evident need for custodial care was now attributed to their age rather than to their chronic schizophrenia and long-term custodial history. The myth about these patients has been augmented by life-cycle professionals who endeavor to set up programs in mental hospitals for geriatric patients, but who fail to distinguish between those aged who developed mental disorder in their early life, such as schizophrenics, and persons who developed mental disorder in old age (Kahn & Zarit, 1974). Since the management of older patients in mental hospitals did not fit the new treatment philosophy, it was considered preferable to shift them to other institutions, still complacently custodial.

The philosophy of custodialism is so entrenched that benevolent gerontological planners talk about the need to provide custodial care as part of any new comprehensive care system. Since there are persons who manifestly fit the custodial operation, it is easy to overlook the fact that the need for custodial care is highly exaggerated and that its very application is self-perpetuating. Studies of aged persons in custodial settings have demonstrated the phenomena of "excess disability" (Kahn, 1971) in which the level of function is poorer than the patient's physiological capability (Brody, Kleban, Lawton, & Silverman, 1971; Kelman, 1962). Excess disability is characteristic of both self-care and cognitive functioning. A person may have all the necessary physiological capacities yet be unable to feed or bathe himself. Cognitively, the old person may show "unorientation" (Kahn, 1971), a state in which the impairment demonstrated in areas where the patient has personal and emotional involvement is greater than the impairment shown in more neutral areas. Thus, he may know the date or the name of the President of the United States, but be unable to state where he is, even after having been in residence for months or years. In a large-scale institutional study it was found that the level of mental status of aged patients was related to certain characteristics of the institutions, being better when the institution was less custodial (Kahn, 1961). It has been demonstrated that breaking down the custodial pattern of a mental hospital ward by mixing young and old patients on the same ward will result in improved cognitive function in the older patient (Kahana & Kahana, 1970).

---

[3] Sometimes the effects of the ideological shift are not properly appreciated because of the temporal proximity of the use of chemotherapy. The large-scale use of drugs, which began in the middle 1950s, coincided with the start of the reduction in the resident patient population in mental hospitals. But the changes in ideology and practice antedated the drugs. Macmillan (1958), for example, started opening his hospital in 1945 and completed the changeover in 1952.

Although there is much difference of opinion among gerontologists on the use of institutions, assaults are now appearing from new directions, and some of the basic assumptions and practices of custodialism are being challenged. Notable among these are new research findings (Schaie, 1974) which question the generality of cognitive decline with age, findings which, by undercutting one of the stereotypes about "senility," are also undercutting one of the stereotypes about the need for custodial care.

Effects of Social Class

The relationship between age and custodialism can be explained further on the basis of cohort differences in social class. It is a well-established research finding that mental health treatment varies according to the social status of the patient, with upper-class persons receiving psychological treatment such as psychotherapy and psychoanalysis, while lower-class patients receive somatic therapy and custodial care (Hollingshead & Redlich, 1958). Since, compared to the young, a higher proportion of the old have been poorly educated, and a higher proportion of old mental patients are working class rather than middle class, differences in treatment reflect these social class differences, thus compounding the age difference.

The effects of social class are complex and do not necessarily reflect discriminating prejudice. The new treatment philosophies, whether represented by the "therapeutic communities" or some form of psychotherapy, emphasize verbal interaction and the patient's recognition of psychological causation of mental disorder. Since these are the very characteristics that distinguish social classes, the aged may be treated custodially not only because they are aged, but because, with their lesser education and other cultural differences, they are less receptive to verbal psychological treatments (Hollingshead & Redlich, 1958; Kahn, Pollack, & Fink, 1957).

Thus there is mutual avoidance: the mental health professionals prefer the young, educated patients, and the aged reject the psychological treatments of psychotherapy and psychoanalysis so highly valued by the professional.

Age Appropriateness

In addition to the social class factors, there may be an intrinsic life cycle phenomenon of age appropriateness for types of psychiatric treatment. Comparable to attitudes toward other life events, there is apparently a sense that psychiatric treatment is appropriate or optimum at a given time of life. Certainly the professionals, starting with Freud himself, have encouraged the notion that psychological treatment is best undertaken early in life. Among the present-day young it may be almost a status symbol to be in treatment, but for the present-day old it is a disgrace.

A LOOK AT THE FUTURE

From this analysis insights can be derived regarding critical theoretical issues regarding mental illness and treatment in the aged and how these will be affected by changing social factors by the year 2000.

Effects of Changes in the Aged

Perhaps the major changes in the relationship of custodialism and the aged in the year 2000 will come about because of predictable changes in the aged themselves. We know that they will have characteristics of higher social status: much better education—the median education will be high school graduation, far fewer numbers of foreign-born, and more social and political awareness. These people will have much less tolerance for custodialism in all its aspects, including the use of custodial institutions such as nursing homes.

The aged are also likely to be much better off because of better economic resources through improved pensions and social security, better comprehensive medical care, and better preparation for, and participation in, retirement. Because of all these changes the aged may actually manifest fewer extreme cases of disordered behavior for which custodial care might be considered.

Effects of Changes in the Professionals

The mental health professionals can also be expected to change significantly. Responding partly to the improved social status of the aged, no longer contaminated in their thinking by large numbers of chronically institutionalized schizophrenics who will have died off, and with a greater awareness of the etiology and modifiability of acute organic brain syndromes, the professional will also eschew custodialism and will become increasingly concerned with prevention in all its aspects. Although primary prevention through such measures as good nutrition will be major efforts, secondary and tertiary prevention will also receive greater attention than today. These will stress mitigating or terminating a disorder once it is manifest by using such methods as early detection and crisis intervention, and reducing the disabilities consequent upon disorder by using such techniques as the therapeutic community and rehabilitation. At the very least, there will be a recognition that the negative consequences of mental dysfunction can be minimized by exposing old persons to more demanding and stimulating environments, in contrast to the isolation and dependency effects of the custodial institution. There will be less infantilization and greater opportunities for the old person to maintain control of his own situation.

Needed New Developments

New developments within the mental health system must also be undertaken directly. For one thing, the very fact of increasing numbers of the aged require new approaches.[4]

Concepts for new programs that should be developed, as well as the operational examples, already exist, although decisive evaluative studies remain to be done. Allowing for many variations depending on the resources of specific settings, the following are suggested as guiding principles:

(1) Mental health and illness are not categorically different, and the same individual will have both healthy and pathological components of personality. As much as possible we should respond to the healthy aspects rather than reinforce the "sick role."

(2) Psychopathology is not fixed or inevitable within the organism, even with altered central nervous system dysfunction. Different environments produce different consequences on function, contributing to enhancement or to deterioration.

(3) "Senility" is a psycho-social-biological phenomenon. Although we may have limited means for changing the biological component, the psychological and social factors are modifiable.

(4) If an old person is under protective care, his functional level should correspond to his physiological capacity.

(5) Intervention can be harmful as well as helpful. Although resources for intervention should be available when needed, it is best to follow a policy of *minimal intervention*: that is, intervention that is least disruptive of usual functioning in the usual setting. Thus, it would be more sensible to provide care in the home or day-care center than in the hospital; in the storefront rather than in the clinic; in the neighborhood rather than downtown; for brief rather than for long periods; with neighborhood personnel rather than with explicit medical or social agency professionals.

Minimal intervention as a positive concept must be differentiated from neglect. It must also be differentiated from "maximal-minimal" intervention, in which the person is removed from his community, then placed in an institution that provides no psychological or social compensatory measures.

---

[4] From a conventional viewpoint, the problem would be almost insoluble if we reckoned the fantastic costs or professional needs as described by Kramer (1973b). For example, reckoning on a 20% psychiatric need in the total population in the year 1980, and providing a total of 10 hours of care per year per patient per discipline, he indicates that over 300,000 professionals will be required in each of the disciplines of psychiatry, psychology, and nursing, with an additional 609,300 social workers needed to provide minimal service.

(6) Effective care is quite different from the *number* of services. The structural dynamics may be far more important than the component parts. In particular, *continuity of care* is essential, in which personnel, agencies, and institutions are integrated. The same personnel should be able to deal with the person in a variety of settings, whether in or out of the institution. Institutions will not be as effective if they are encapsulated units, even with high staff/patient ratios, as if they are part of a coordinated comprehensive system.

(7) Both the needs of the old person and his family must be considered. More good may be done for both by providing supportive help to the family, for example, than by dealing directly with the patient's psychosis. One of the most useful techniques is to provide "holiday relief," in which the old person may be hospitalized for a week or two to enable the family to take a vacation. This limited support may often be sufficient to prevent permanent institutionalization of the old person.

There may also be a legitimate conflict of interests. It may relieve emotional pressures on a family to place an old person in an institution permanently, but the effects of the move may be deleterious to the old person. In those cases, ethical as well as clinical judgment is required.

(8) Expectations may be decisive in achieving mental health goals. In using an institution, for example, setting a time limit at the point of entry may help the old person, his family, and the institution to act in ways more likely to lead to his return home.

(9) *Decentralization* and *"de-medicalization"* of services are desirable. Outreach workers, nonprofessionals preferably coming from the same background, same neighborhood, and same general age group as the prospective clients, would be the first line of contact, serving at least in a confidante role, providing the liaison to professionals. The latter would serve as indirect consultants to nonprofessionals, providing brief *direct* service only to a small number of persons, but providing *indirect* consultation to "firing line professionals such as police, clergymen, general physicians, and to others such as bank tellers, bus drivers, and storekeepers." Most persons could be helped without ever becoming an administratively official "patient" or "client."

(10) Instead of being the passive recipient of services which the professional decides are good for him, the old person's sense of control should be maintained. The very act of being helped can have the paradoxical effect of increasing the impairment because of the infantilization and sense of loss of control that results.

(11) Those principles can be carried further by realizing that *"potential service"* may be as useful as any form of *actual* help. The basis of this concept is to guarantee that service will be available when needed. If a community were assured of the validity of the commitment of service it would be increasingly possible to cope with many problems, either autonomously or with minimum help, that might otherwise have involved more extensive use of resources. Thus, guaranteeing that brief hospitalization will always be available when needed should not only reduce the amount of long hospitalization, but the amount of brief hospitalization as well.

(12) The most effective mental health programs for the aged have been achieved in the context of the public health technique of a geographically-defined catchment area (e.g., Macmillan, 1958; Perlin & Kahn, 1967). By explicitly defining the responsibility and commitment for a given target population and physical locale, there has been the greatest opportunity for facilitating such necessary components as comprehensiveness and continuity of care, guaranteed service, and maximum use of community resources. In practice the application of the catchment area concept has resulted in providing for the mental health needs of the entire population. (Without such a definition, programs follow the conventional criteria for selecting patients, resulting in the characteristic biases toward the aged, so that their needs are overlooked or evaded by "dumping" old people into an external institution or resource.)

These concepts and changed practices have considerable promise in meeting the mental health needs of the aged by the year 2000. They will have an impact on both the established mental health system and the innovative community services. The new approaches may have the multiple virtues of not only being more effective than many conventional practices but also far more economical and efficient in the use of our resources.

References

Brody, E. M., Kleban, M. M., Lawton, M. P., & Silverman, H. A. Excess disabilities of mental impaired aged: Impact of individualized treatment. **Gerontologist**, 1971, 11, 124-132.

Carse, J., Panton, N. E., & Watt, A. A district mental health service: the Worthing experiment. **Lancet**, 1958, 1, 39-42.

Epstein, L. J., & Simon, A. Alternatives to state hospitalization for the geriatric mentally ill. **American Journal of Psychiatry**, 1968, **124**, 955-961.

Gilbert, D. C., & Levinson, D. J. Ideology, personality and institutional policy in the mental hospital. **Journal of Abnormal & Social Psychology**, 1956, **53**, 263-271.

Greenblatt, M., Levinson, D. J. & Williams, R. **The patient and the mental hospital.** Free Press, Glencoe, IL, 1957.

Greenblatt, M., York, R., & Brown, E. L. **From custodial to therapeutic care in mental hospitals.** Russell Sage Foundation, New York, 1955.

Grob, G. N. **The state and the mentally ill.** Univ. of North Carolina Press, Chapel Hill, 1966.

Hollingshead, A. B., & Redlich, F. C. **Social class and mental illness.** John Wiley, New York, 1958.

Jones, M. **The therapeutic community.** Basic Books, New York, 1953.

Kahana, E., & Kahana, B. Therapeutic potential of age integration: Effects of age integrated hospital environments on elderly psychiatric patients. **Archives of General Psychiatry**, 1970, **23**, 20-29.

Kahn, R. L. Psychological aspects of aging. In I. Rossman (Ed.), **Clinical geriatrics.** J. B. Lippincott, Philadelphia, 1971.

Kahn, R. L., Pollack, M., & Fink, M. Social factors in the selection of therapy in a voluntary mental hospital. **Journal of Hillside Hospital**, 1957, **6**, 216-228.

Kahn, R. L., Pollack, M., & Goldfarb, A. I. Factors related to individual differences in mental status of institutionalized aged. In P. Hoch & J. Zubin (Eds.), **Psychopathology of aging.** Grune & Stratton, New York, 1961.

Kahn, R. L., & Zarit, S. H. Evaluation of mental health programs for the aged. In P. O. Davidson, F. W. Clark, & L. A. Hamerlynck (Eds.), **Evaluation of behavioral programs.** Research Press, Champaign, IL, 1974.

Kellman, H. R. An experiment in the rehabilitation of nursing home patients. **Public Health Reports.** PHS, DHEW, 1962, **77**, 356-366.

Kramer, M. Historical tables in changes in patterns of the use of psychiatric facilities 1946-1971. Biometry Branch, NIMH, Rockville, MD, 1973. (a)

Kramer, M. Implications of expected changes in composition of the U. S. population for the delivery of mental health services during the period 1971-1985. Paper presented at the Southeastern Divisional Meeting of the American Psychiatric Assn., Williamsburg, VA, Oct., 1973. (b)

Lawton, M. P., & Gottesman, L. E. Psychological services to the elderly. **American Psychologist**, 1974, **29**, 689-693.

Macmillan, D. Hospital-community relationships. In **An approach to the prevention of disability from chronic psychoses: The open mental hospital within the community.** Milbank Memorial Fund, New York, 1958.

Main, T. The hospital as a therapeutic institution. **Bulletin of the Menninger Clinic**, 1946, **10**, 66-70.

Malzberg, B. **Mental disease in New York State 1910-1960: A study of incidence.** Research Foundation for Mental Hygiene, Albany, 1967.

Perlin, S., & Kahn, R. L. The development of a community mental health center model. In **Psychiatric Research Report 22**, American Psychiatric Assn., Washington, 1967.

Polak, P., & Jones, M. The psychiatric nonhospital: A model for change. **Community Mental Health Journal**, 1973, **9**, 123-132.

Redick, R. W. Patient care episodes in psychiatric services, United States 1971. **Statistical Note 92.** Biometry Branch, NIMH, Rockville, MD, 1973.

Redick, R. W. Patterns in use of nursing homes by the aged mentally ill. **Statistical Note 107.** Biometry Branch, Rockville, MD, 1974.

Schaie, K. W. Translations in gerontology—from lab to life: Intellectual functioning. **American Psychologist**, 1974, **29**, 802-807.

Stanton, A., & Schwartz, M. **The mental hospital.** Basic Books, New York, 1954.

Willner, S. G. Patients resident in mental hospitals by type of hospitals, United States, 1904-1970. Biometry Branch, NIMH, Rockville, MD, 1974.

BEST COPY AVAILABLE

Copyright 1985 by
The Gerontological Society of America

Data describing elderly interstate migration patterns were compared for the 1960, 1970, and 1980 censuses. Florida dominates as a destination, and its attractiveness is increasing. Arizona and Texas are also increasing in attractiveness, but California and New Jersey have a decreasing share of elderly migrants. Elderly migrants are becoming even more concentrated in only a few destinations, which makes the impact of the migration patterns on service delivery especially significant in those states.

Key Words: Elderly, Migration patterns, Interstate migration, Older people, Population change

The Redistribution of America's Older Population: Major National Migration Patterns for Three Census Decades, 1960–1980[1]

Cynthia B. Flynn, PhD,[2] Charles F. Longino, Jr., PhD,[3]
Robert F. Wiseman, PhD,[4] and Jeanne C. Biggar, PhD[5]

This report of the first findings of the final phase of the Retirement Migration Project examines the 1980 migration patterns of the United States population age 60 years and older in the context of two earlier census decades, 1960 and 1970. Other reports will later analyze two-decade changes in the selectivity of migrant characteristics within major state-to-state streams and the impact of retirement migration on small geographic units.

Researchers have reported on the migration patterns of the older population since at least the early 1950s (Barsby & Cox, 1975; Friedsam, 1951; Smith, 1962), and interest in the subject has been enduring. Early research, however, was tentative and sparse. The census did not contain a question about residential relocation until 1940, but the census coverage of migration issues has improved substantially since that time.

Demographers have tended to devalue migration of the elderly, and those who have been interested in retirement migration seemed to be attracted to it as an exotic topic. Demographic research on migration has focused almost entirely on labor force redistribution. The few researchers who considered the migration of the elderly important found themselves trying to adapt labor force concepts to a population that was, for the most part, outside the labor force (Barsby & Cox, 1975). Their frustration discouraged others from pursuing the subject.

Among geographers, research has focused on age as a factor in urban ecology. They are interested in the concentration of older residents in certain parts of the city. Human ecology provided the main conceptual context for the geographers' studies of redistribution patterns of the elderly. Such morphological concerns, however, tended to draw the attention of geographers away from the national picture and toward the particular place, just as labor force concerns diverted the attention of demographers from development of migration theory that would be appropriate for all age groups.

In gerontology, interest in population redistribution is dominated by social policy considerations. For many gerontologists, questions about the impact of migration upon local planning (and funding) issues are more compelling than are theoretical discussions of the dynamics of abstract macro-level exchange systems. In this respect, gerontological demography seems more closely akin to population demography and market research than to theoretical demography. Yet, although gerontology has historically concentrated research interest more on policy issues than on the systematic reformulation of demographic migration theory, it has the potential for extending the focus of migration theory beyond labor force movement to include retirement and dependency moves. Until this happens, the migration of older persons will remain an offbeat, unusual research area of little serious academic relevance. Many of these first findings of the Retirement Migration Project are descriptive and even useful, while its long-range goals are more analytical and theoretical.

---

[1] The data reported in this paper were derived from grant No. AG02360 from the National Institute on Aging. The authors gratefully acknowledge the assistance of Carol Welch, Betsy H. Corcoran, and Donna J. Tolson.

[2] Social Impact Research, Inc., 2033 Sixth Avenue, Suite 1111, Seattle, WA 98121.

[3] University of Miami, Department of Sociology, P. O. Box 248162, Coral Gables, FL 33124.

[4] University of Kansas, Department of Geography, Lawrence, KS 66045.

[5] University of Virginia, Department of Sociology, 544 Cabell Hall, Charlottesville, VA 22903.

BEST COPY AVAILABLE

Data Sources and Presentation

Interstate migrants are defined as persons who lived in a different state exactly 5 years before the census day. The information reported in this paper on such migrants was drawn from two sources, the Census Bureau's printed documents and the data from the 1960, 1970, and 1980 census microdata files. Printed documents were preferred to microdata whenever possible because they are based on population rather than sample data and are, therefore, more accurate. When printed documents are not available, 100% population estimates are made from the sample (1% in 1960 and 1970; 2.5% in 1980) of the individual census records of the migrants in the microdata tapes.

Four tables are presented below. Table 1 shows how the general and elderly populations and the interstate migrants from those two populations have grown since 1960. The general interstate migration rate is based on a population that excludes children under age 5, persons who moved from abroad, and persons who moved but did not report their previous residence. Table 2 lists all the interstate migrants who were 60 years of age or older on the census day in
each decade and shows the number and the perce
age of this population that moved into each of t
top 10 destination states. The 1960 and 1970 figu
were drawn from printed reports; the 1980 figu
are 100% population estimates produced from t
microdata sample and reported in thousands. Tabl
is identical to Table 2 except that it deals with o
migrants and information for 1960 is not incluc
because state of origin is not recorded on the 19
microdata records. Table 4 is more complex than t
other tables. The first of its two double colum
headed "Attractiveness," shows the proportion of
older migrants who moved into each state. Obvio
ly, sparsely populated states have some built-in u
attractiveness because of their population size, a
Alaska, not surprisingly, captured only one-tenth
1% of all elderly interstate migrants. The second do
ble column, "Impact," shows what percentage
each state's older population moved there betwe
1975 and 1980. Although Alaska captured only .1%
all interstate migrants, these 1,520 migrants made
7.7% of Alaska's older population in 1980, havin
proportional impact comparable to that in Arkan
or Colorado. The rankings for states other than

Table 1. Changes in the Numbers of Persons and Interstate Migrants between 1960 and 1980 for the General Population and for the Population Age 60 Years and Over

Persons	1960		1970		1980		% Change in Volu	
	n (000s)	Rate	*n* (000s)	Rate	*n* (000s)	Rate	1960–70	197
Total U.S. Population	179,323		203,302		226,546		13.4	11
Age 60+ Population	22,820		27,538		35,637		20.7	29
Interstate Migrants:								
Age 5+	14,141	9.2	16,081	9.3	20,358	9.9	13.7	26
Age 60+	959	4.1	1,105	4.0	1,654	4.6	15.2	50

Sources: *U.S. Census of Population, 1960, General Population Characteristics, Final Report; U.S. Census of Population, 1970, Ger Population Characteristics, Final Report: U.S. Bureau of the Census (1983), 1980 Public use microdata sample A* [Machine-readable file], Washington, DC: U.S. Bureau of the Census (Producer and Distributor).

Table 2. Ten States Receiving the Largest Share of In-Migrants Age 60+ in 1960, 1970, and 1980

Rank	1960			1970			1980[a]	
	State	*n*	%	State	*n*	%	State	*n*
1	FL	208,072	22.3	FL	269,141	24.6	FL	437,000
2	CA	126,883	13.6	CA	109,342	10.0	CA	145,000
3	NJ	36,013	3.9	AZ	46,451	4.2	AZ	95,000
4	NY	33,794	3.6	NJ	43,597	4.0	TX	78,000
5	IL	30,355	3.3	TX	38,682	3.5	NJ	49,000
6	AZ	29,571	3.2	PA	34,006	3.1	PA	40,000
7	OH	27,759	3.0	OH	30,492	2.8	NC	39,000
8	TX	26,770	2.9	NY	30,388	2.8	WA	36,000
9	PA	25,738	2.8	IL	29,434	2.7	IL	36,000
10	MI	20,308	2.2	MO	24,395	2.2	NY	35,000
Total Interstate Migrants		931,012			1,094,014			1,654,000
% of Total in Top 10 States			60.8			59.9		

[a] Estimated numbers are rounded to the nearest thousand.

Sources: *U.S. Census of Population, 1960, Detailed Population Characteristics,* Table 100; *U.S. Census of Population, 1970, De Population Characteristics,* Table 145; *U.S. Bureau of the Census (1983), 1980 Public use microdata sample A* [Machine-readable data Washington, DC: U.S. Burea of the Census (Producer and Distributor).

Table 3. Ten States Sending the Largest Share of Out-Migrants Age 60+ in 1970 and 1980

	1970			1980[a]		
Rank	State	*n*	%	State	*n*	%
1	NY	154,300	14.3	NY	243,000	14.6
2	IL	86,900	8.1	CA	141,000	8.5
3	CA	74,400	6.9	IL	120,000	7.2
4	PA	53,000	5.0	FL	92,000	5.6
5	OH	53,400	5.0	NJ	87,000	5.2
6	MI	52,600	4.9	OH	86,000	5.2
7	NJ	50,100	4.6	PA	81,000	4.9
8	FL	46,000	4.0	MI	72,000	4.3
9	TX	30,300	2.8	MA	47,000	2.8
10	IN	29,200	2.7	IN	40,000	2.4

[a] Numbers estimated from the sample are rounded to the nearest thousand.

Sources: U.S. Bureau of the Census (1983), *1% 1970 and 1-in-40 1980 Census public use microdata samples* [Machine-readable data file], Washington, DC: U.S. Bureau of the Census (Producer and Distributor).

top 10 states on both attractiveness and impact are tentative because the differences between them are so small and because they are estimates based on a sample.

After the data in Table 1 are reviewed, notable findings from the remaining tables will be summarized in a discussion of the three-decade migration trends in seven key states.

Findings

The number of elderly migrants increased dramatically over the three census decades, from fewer than a million in the 1955–1960 migration period to more than 1.6 million in 1975–1980. The skeptic would point out that the older population increased by almost 21% between 1960 and 1970 while elderly migrants increased by only 15%; indeed, the rate of interstate migration per 100 older persons actually shrank slightly in 1965–1970 (4.0%) as compared with the earlier decade (4.1%).

Since the older population increased at an even higher rate (29.4%) between 1970 and 1980, that same skeptic might expect the migration increase again only to reflect population growth, but this was not the case. During this decade, the number of migrants grew by 50%, nearly double the national elderly population increase. Furthermore, older migrants increased between 1970 and 1980 at almost double the increase of migrants in the general population (50% versus 26.6%). Only about 4 older persons per 100 are interstate migrants in any recent migration period as compared to about 9 persons per 100 in the general population. If the higher decade increases in elderly migration continue, however, the gap will gradually be narrowed. The next census could easily reveal that the migration rate of older persons has for the first time become more than half that of the general population. In short, retirement migration is becoming more common by the decade.

Table 4. Volume of Older In-Migrants in All States and Rankings of Attractiveness and Impact, 1975–1980

		Attractiveness[a]		Impact[b]	
State	Volume	%	Rank	%	Rank
Alabama	17,200	1.03	29	2.82	35
Alaska	1,520	.09	49	7.74	9
Arizona	94,600	5.69	3	21.[illegible]	1
Arkansas	33,760	2.03	12	7.98	5
California	144,880	8.71	2	4.25	23
Colorado	27,160	1.63	18	7.76	7
Connecticut	18,320	1.10	27	3.43	28
Delaware	6,680	.40	42	7.76	8
District of Columbia	3,560	.21	46	3.43	31
Florida	437,040	26.29	1	19.40	2
Georgia	33,360	2.00	14	4.55	19
Hawaii	5,640	.34	43	4.94	14
Idaho	2,120	.55	37	6.91	10
Illinois	35,720	2.15	9	2.01	45
Indiana	23,120	1.39	23	8.82	34
Iowa	11,320	.68	36	2.17	42
Kansas	14,880	.90	31	3.60	27
Kentucky	17,880	1.07	28	3.17	32
Louisiana	12,120	.73	35	2.14	43
Maine	8,880	.53	38	4.63	17
Maryland	24,600	1.48	20	4.27	22
Massachusetts	21,920	1.32	22	2.18	41
Michigan	24,920	1.50	19	1.91	47
Minnesota	13,800	.83	32	2.12	44
Mississippi	13,800	.83	32	3.51	29
Missouri	30,400	1.83	17	3.48	30
Montana	5,360	.32	44	4.50	20
Nebraska	7,960	.48	41	2.91	33
Nevada	24,160	1.45	21	2.40	39
New Hampshire	12,480	.75	34	8.75	4
New Jersey	49,400	2.97	5	4.02	26
New Mexico	17,160	1.03	30	10.42	3
New York	34,920	2.10	10	1.16	49
North Carolina	39,400	2.37	7	4.59	18
North Dakota	2,560	.15	48	2.36	40
Ohio	32,680	1.97	15	1.97	46
Oklahoma	22,600	1.36	24	4.46	21
Oregon	33,600	2.02	13	7.98	6
Pennsylvania	39,520	2.38	6	1.83	48
Rhode Island	4,360	.26	45	2.47	38
South Carolina	20,560	1.24	25	4.94	15
South Dakota	400	.02	51	.00	51
Tennessee	29,040	1.75	16	4.04	25
Texas	78,480	4.72	4	4.12	24
Utah	8,520	.51	40	5.48	13
Vermont	460	.03	50	.00	51
Virginia	34,280	2.06	11	4.81	16
Washington	35,880	2.34	8	5.88	11
West Virginia	8,600	.52	39	2.60	36
Wisconsin	19,640	1.18	26	2.55	37
Wyoming	2,920	.18	47	5.55	12

[a] Percentage of all U.S. interstate migrants age 60+.

[b] Percentage of the state's age 60+ population who moved there since 1975.

Source: U.S. Bureau of the Census (1983), *1-in-40 1980 Census public use microdata samples* [Machine-readable data file], Washington, DC: U.S. Bureau of the Census (Producer and Distributor).

Florida. — Florida dominates the migration destination states. Nearly half a million older migrants (437,000) moved to Florida between 1975 and 1980, and the proportion of all elderly migrants who are attracted to the state of Florida continues to increase (Table 2). For the first time in 1980, more than a quarter of all persons 60 years of age and older who moved across state lines moved to Florida. This state also ranked fourth among the top 10 *sending* states (Table 3) as the origin of 5.6% of all elderly out-migrants in the United States.

Considering Florida's sustained history of attractiveness to retirement-aged migrants, we would expect its in-migrants to gradually become a smaller percentage of its older population, attenuating their impact upon the state. Since the total national volume of migration in this age group increased substantially during the 1970s, however, new migrants to Florida still made up a fifth of its older population. Only in Arizona did new migrants constitute a larger percentage of all of a state's elderly population.

California. — California increased its total volume of in-migrants in 1980, but its relative share of all migrants in the U.S. continued to drop. In the 1960 census, it captured 14% of the total pool of interstate elderly migrants, but that proportion declined to 10% in 1970 and to 9% in 1980. Like Florida, California is also a major origin state. The 141,000 migrants it sent to other states placed it in second rank as a sending state, led only by New York. During the 1975–1980 migration period, California lost nearly as many older persons through migration as it gained.

In 1980, California ranked only 23rd in the proportion of its older population who were recent arrivals (Table 4), with fewer than 5% of the elderly inhabitants moving there since 1975. Although California remains a leading destination for elderly migrants, a significant portion of California's elderly are aging in place or moving to other states. Unlike Florida, in California recent in-migrants do not constitute a significant percentage of the older population.

Arizona. — In-migration to Arizona has increased both absolutely and relatively. It received nearly twice as many in-migrants in 1980 as in 1970 and the total more than tripled between 1960 and 1980 (Table 2). This state is clearly experiencing one of the most dramatic increases in the migration of retirement-aged persons anywhere in the country. At its present growth rate, Arizona may even edge out California as the second-ranked destination by 1990.

When there are large migration streams into a state, normally counterstreams develop back to the major sending states, and these counterstreams account for an appreciable share of a state's out-migration. Unlike Florida and California, however, Arizona was not among the top 10 sending (origin) states in 1980. The recentness of Arizona's ascent to the leading ranks of retirement destinations may account for its low rank as a sending state (Table 3) since counterstream development there may still be in its early stages. Arizona ranks first in impact because of its rapid growth. Over a fifth of Arizona's older citizens are recent arrivals.

Texas. — The pattern for Texas is similar to that
Arizona in that it increased both absolutely and
atively in each of the time periods and it lack
significant counterstream back to origin states.
impact of the migration, however, is not notewort
one place lower than California, Texas ranks 24th
the percentage of its elderly who are recen
migrants.

New Jersey. — The relative attractiveness of
Jersey as a retirement destination is declining, e
though the volume of migration into that state c
tinues to increase (Table 2). New Jersey's r
dropped from third in 1960 to fourth in 1970 and f
in 1980. Many migrants from New York settled in
Jersey three decades ago, but the number of att
tive locations has increased since then and so h
the financial capabilities of the retirement-a
population. Perhaps New Jersey has not been abl
compete well in this changing migration mar
place.

North Carolina. — Half of the top 10 destina
states are in the Sunbelt since North Carolina jo
the list in 1980. Its ascent has been rapid; it ra
27th in 1960, 17th in 1970, and seventh in 1980.
number of persons 60 years of age and over
moved into North Carolina between 1975 and
more than doubled since the 1965–1970 migr
period a decade earlier and nearly quadrupled s
1955–1960. Its rate of increase has been substan
greater, although its total volume is still less than
that of Arizona. It could become the "Arizona o
East" and therefore bears watching.

Washington. — Washington was also amon
top 10 destination states for the first time in 19
ranked eighth. In both 1960 and 1970, it ranked
The number of Washington in-migrants 60 yea
age and older increased 73% between 1970 and
and has more than doubled since 1960 (Table 2)
proportion of recent migrants in Washington's
population has been rising in each decade
1960; it ranked 17th in migration impact in 1960
in 1970, and 11th in 1980 (Table 4). Although it
often mentioned as a primary retirement destin
Washington is clearly gaining in popularity. An
sis of the pattern of migration into Washingt
1970 (Flynn, 1980) identified it as a major re
destination prior to the most rapid increase
elderly in-migration.

Summary and Conclusions

Migration trends first noticed in the 195
period have continued through 1975–1980. F
for example, is the dominant destination for mi
who are elderly and has become more appealin
the three decades. Arizona and Texas are bec
relatively more and California and New Jers
becoming relatively less attractive to elde
migrants. No reversals are apparent in any o
trends.

BEST COPY AVAILABLE

The concentration of older migrants in only a few destination states continues, with about half of them moving to the top 5 destination states, and about 60% moving to the top 10. This leaves only 40% for the remaining 40 states and the District of Columbia.

Sunbelt states receive half of the older migrants. This is commonly perceived, but it is important to point out that not all Sunbelt states are attracting large numbers of older migrants. Indeed, some of the most populous northern states (New York, New Jersey, Pennsylvania, and Illinois) attract a larger volume of migrants age 60 and over than do several of the smaller Sunbelt states such as South Carolina, Alabama, Mississippi, Louisiana, and New Mexico.

These preliminary findings of the 1980 census data provide only a summary picture of the overall migration patterns for persons of retirement age. Reports drawn from the 1960 and 1970 microdata files have included more complex and detailed analyses. Examples are 1) transaction flow analyses identifying unusually large state-to-state migration streams (Biggar, 1980; Flynn, 1980), 2) studies of patterns of migration between metropolitan and nonmetropolitan locations (Longino, 1980, 1982a), 3) return migration to one's state of birth (Longino, 1979), and 4) the characteristics which distinguish migrants in different streams as well as from local movers and stayers (Biggar et al., 1980; Biggar et al., in press; Longino & Biggar, 1981, 1982). Each of these analyses will be updated and compared with the 1980 data so that established trends can be extended, many of them to the third decade (Biggar et al., in press; Longino et al., 1984).

The 1980 microdata files now permit the analyses of migration streams to and from substate units with over 100,000 residents. This makes it possible for the first time to pinpoint migration streams from one metropolitan county to another anywhere in the nation and to study the characteristics of the migrants in the larger streams. As Longino (1982b) has pointed out, the issue of impact is most important for state and area agency planners in these substrate geographical units where stream data are now available. If further research shows that migrants in a particular stream share characteristics which differ significantly from the characteristics of the elderly at the migration destination, planners can develop intervention strategies to improve the quality of life for both the in-migrants and other elderly at the destination.

References

Barsby, S. L., & Cox, D. R. (1975). *Interstate migration of the elderly.* Lexington, MA: D. C. Heath.

Biggar, J. C. (1980). Who moved among the elderly, 1965–70: A compariso of types of older movers. *Research on Aging, 2,* 73–91.

Biggar, J. C., Cowper, D. C., & Yeatts, D. E. (in press). National elderly migration patterns and selectivity, 1955–60, 1965–70, and decade trends *Research on Aging.*

Biggar, J. C., Longino, C. F., Jr., & Flynn, C. B. (1980). Elderly interstat migration: The impact on sending and receiving states, 1965 to 1970 *Research on Aging, 2,* 205–216.

Flynn, C. B. (1980). General versus aged interstate migration. *Research o Aging, 2,* 165–176.

Friedsam, H. J. (1951). Interregional migration of the aged in the U.S. *Journa of Gerontology, 6,* 237–242.

Longino, C. F., Jr. (1979). Going home: Aged return migration in the U.S. 1965–70. *Journal of Gerontology, 34,* 736–745.

Longino, C. F., Jr. (1980). Residential relocation of older people: Metropolitan and nonmetropolitan. *Research on Aging, 2,* 205–216.

Longino, C. F., Jr. (1982a). Changing aged nonmetropolitan migration patterns, 1955 to 1960 and 1965 to 1970. *Journal of Gerontology, 37,* 228–234

Longino, C. F., Jr. (1982b). Symposium: Population research for plannin and practice. *The Gerontologist, 22,* 142–143.

Longino, C. F., Jr., & Biggar, J. C. (1981). The impact of retirement migratio on the South. *The Gerontologist, 21,* 283–290.

Longino, C. F., Jr., & Biggar, J. C. (1982). The impact of population redistribution upon service delivery. *The Gerontologist, 22,* 153–159.

Longino, C. F., Jr., Wiseman, R. F., Biggar, J. C., & Flynn, C. B. (1984) Forerunners of change: Aged metropolitan nonmetropolitan migratio streams over three census decades. *Journal of Gerontology, 39,* 721–729

Smith, T. L. (1962). Changes in the number and redistribution of the age population of the United States. In C. Osterbind (Ed.), *Aging in a changing society.* Report on the Eleventh Annual Southern Conference o Gerontology. University of Florida Press, Gainesville.

BLANK PAGE

The instructor might want to begin the section on Normal Aging by administering Palmore's Facts on Aging quiz, or the quiz could be administered, as a review, at the end of the session. The class could respond verbally and discuss their answers.

It is important to emphasize to students that the changes that take place in our bodies, as we age, occur slowly. These changes begin many years before we reach 55 or 60. In brief, it can be safely said that as we age our bodies begin to slow down and become a little less efficient. Our senses will need more stimulation to trigger the receptors. These changes are gradual and most people adapt to them with little or no notice. This is generally true throughout our body systems.

Emphasize to the students that most losses occur in what is called the reserve capacity of our body. This reserve capacity is called upon in times of stress. Therefore, as we become older, it may take us longer to "bounce back" from a period of stress.

This is also a good time to discuss, for the first time, the various types of stress that exist; physical, psychological, social, and financial. Examine effects of stress and note that stress begets stress! Keep this discussion brief and on topic as this will be the first of many opportunities to discuss stress and its effects upon the elderly.

As you go through the body systems and discuss normal age related changes, point out that certain conditions are commonly found among older people, but are not normal age related changes (for example, arthritis and cataracts). Remind students that different people age at different rates and that different parts of our own bodies age at different rates.

Chronological age is one of the poorest predictors of how old we are. A baseball player and a first-time mother may be perceived as old at forty. A forty year old presidential candidate worries about being too young for the position and if the next chairman of the board of General Motors is forty, he or she will be referred to as a "whiz kid." Heredity, general health, and our living-working environment have more to do with how our bodies age than our birth date does.

NORMAL AGING

Name: ______________________________ **Date:** __________________

CIRCLE THE CORRECT ANSWER.

1. The model of aging that recognizes continuous growth and development is:

   a. medical
   b. social
   c. psychological

2. The most prevalent chronic condition among the elderly is:

   a. Alzheimer's disease
   b. arteriosclerosis
   c. arthritis

3. The major causes of change in the functioning of the physiological systems over time are heredity, illness, and:

   a. loneliness
   b. accidents
   c. death of spouse

4. The most common age-related sensory deficit is impairment of:

   a. hearing
   b. sight
   c. smell

5. When it comes to knowing the true facts about normal aging, most people and the elderly themselves tend to believe myths ___________ than the truth.

   a. more often
   b. stranger
   c. less often

6. Besides illness, the primary factors inhibiting sexual behavior in the elderly are:

   a. physiological changes which preclude both sexes from having satisfactory sexual relations
   b. the climacteric in men; menopause in women
   c. psychological and social pressures

7. Dissatisfaction in retirement is usually attributed to financial problems and:

   a. poor health
   b. boredom
   c. loss of self esteem

8. The primary source of income for the elderly is ______________, which account(s) for over 50% of income for recipients.

   a. personal assets
   b. Social Security
   c. private pensions

9. Whereas older people have lower incidences of ________ illnesses than younger people, they suffer more ________ illnesses than younger people.

   a. acute; chronic
   b. chronic; acute
   c. physical; mental

10. Approximately __________ of the total elderly population reside in nursing homes.

    a. 25%
    b. 5%
    c. 40%

Normal Aging

1. c
2. c
3. b
4. a
5. a
6. c
7. a
8. b
9. a
10. b

BLANK PAGE

Problems Relating to Aging

Rationale for a Behavioral Approach

LARRY W. DUPREE,
MICHAEL J. O'SULLIVAN,
AND ROGER L. PATTERSON

Old people are subject to the same problems as younger people. Therefore, when we speak of the problems of the elderly, we are usually referring to common human problems found in greater abundance among older people. A large number of problems of the elderly may be said to be related to major losses which tend to occur more frequently in later life. Those losses include loss of family and social contacts, reduction in work, economic loss, physiological and health impairment, decreased social and cultural status, and lowered self-evaluation. Usually the losses are gradual but also incremental. Thus, the transition from middle to older age may be experienced as a stressful, difficult, and sometimes prolonged period of readjustment, necessitating fairly substantial (and frequent) changes in the individual's life and behavior. This transition period can elicit diverse behavior, with some individuals being unable to adapt to the changes taking place, changes occurring in many areas and often overlapping in time.

THE AGED AS A HIGH-RISK GROUP

Because of the rapid accumulation of changes and the consequent accumulation of stress, the aged are a high-risk group in the area of mental health (Ingersoll & Silverman, 1978). An estimated 15-25% of the elderly have significant mental health problems (U.S. President's Commission on Mental Health, 1978). Kramer and associates summarized seven studies of prevalence rates for mental illness among noninstitutionalized older age groups and estimated that 10–20% were in need of mental health services (Kramer, Taube, & Redick, 1973; Redick, Kramer, & Taube, 1973). Furthermore, older adults account for approximately 25% of the reported suicides each year (Butler, 1975; Butler & Lewis, 1977). It appears to be difficult to obtain highly reliable estimates of prevalence rates for mental illness among the elderly because, as the President's Commission on Mental Health (1978) indicates, a growing trend in recent years has been to transfer older patients out of costly state hospitals into other less expensive boarding situations. This often results in two things: (1) inadequate medical, nursing, social, and mental health care and (2) an exclusion of these residents from prevalence studies of mental disorders among the elderly. Therefore, the rate of mental illness among the elderly may be vastly underestimated. Prevalence data more often are based upon mental hospital and community mental health center data. Yet, the National Center for Health Statistics (1977) reports that 58% of all nursing home residents are considered confused some or most of the time. Thus, a significant population for whom mental health services might be appropriate may not be incorporated within prevalence estimates upon which current need and future services are determined. Libow (1977) points out the applicability of diverse services to confused individuals by noting that among adults who suffer from senile dementia as many as one-third may be reflecting *pseudosenility* or a reversible brain syndrome as a result in errors in medication, malnutrition, metabolic imbalance, and other causes that have the potential for being reversed.

UNDERUTILIZATION OF MENTAL HEALTH SERVICES BY THE ELDERLY

Even though the aged do appear to be a high-risk group in the area of mental health, this population receives a disproportionately small share of mental health services (Butler & Lewis, 1973). For example, the President's Commission on Mental Health (1978) reports that only 4% of the clients seen at public outpatient mental health clinics are elderly, whereas others have reported that 2% of those seen by independent practitioners are elderly (Butler & Lewis, 1977). Not only are the elderly receiving less care than younger individuals, but their rate of care per 100,000 elderly population is dropping (U.S. President's Commission on Mental Health, 1978). The paucity of such

services results both from the reluctance of professionals to deal with this group and from the hesitance of older people to seek psychological help (Ingersoll & Silverman, 1978).

CULTURAL "AGEISM"

Several explanations have been given for the underutilization of services by the elderly. Most of them are in some way related to "ageism." Ageism is age discrimination or the prejudice by one age group toward other age groups (Butler, 1969). Ageism reflects "a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, 'uselessness,' and death" (Butler, 1969, p. 243). Cultural attitudes reinforce these feelings and compound the stress associated with growing older. Yet aging is what our national population is doing. In 1900 there were three million older Americans (age 65 and above) representing 4% of the total population, whereas in 1977 the aged represented 11% (approximately 23 million) of the nation's census (U.S. Bureau of the Census, 1978). Between 1900 and 1977 the total United States population increased by approximately 288% while the category of older Americans grew by approximately 683%. More recently, between 1970 and 1977, the older age group increased by approximately 18%, whereas those under age 65 increased by about 5%. During this period the total population increased by approximately 6%. Thus, both the number and proportion of the elderly have increased and these trends are likely to continue. The total number of older Americans is expected to increase from approximately 23 million in 1977 to 32 million in the year 2000. Even though our national population is aging, aging has been transformed from a natural process into a social problem in which the older individual bears the negative consequences. The extent to which ageism is an obstacle to the apt treatment of elderly individuals is of particular interest in the present context.

PROFESSIONAL AGEISM

In the mental health field ageism has become professionalized. Butler and Lewis (1977) refer to "professional ageism," which in turn refers to the negative attitudes of mental health professionals toward the elderly (Gaitz, 1974; Kastenbaum, 1978; Waters, Fink, & White, 1976). Professional ageism includes a belief that aging means inevitable decline, pessimism about the likelihood and speed of change, and the belief that it is futile to invest effort in a person with limited life expectancy. Of course, such beliefs may not be verbalized, but resultant behavior manifested by professionals correlates highly with such views. For example, estimates are that

> from 10 to 30 percent of all treatable mental disorders in older people are misdiagnosed as untreatable, frequently because the physician assumes that mental impairment is to be expected with advancing age and therefore makes no effort to rule out reversible disorders. (Butler, 1980, p. 9)

Also, as Palmore (1973) points out, the views associated with professional ageism (particularly those noting that mental illness in old age is inevitable, untreatable, disabling, and irreversible) become a self-fulfilling prophecy, leading to a lack of prevention and treatment which in turn tends to confirm the original belief. Caplovitz and Rodin (cited in Rodin & Langer, 1980) noted, that furthermore, professionals often use age as a cue for interpreting behavior and that the labels assigned by professionals affect the behavior of the elderly. In this study, a group of psychologists and psychiatrists were presented with identical descriptions of behavior, with six cases being presented as persons young in age and six as persons in their sixties or seventies. Age influenced both diagnosis and recommendations for treatment, with the elderly more often diagnosed as having an underlying organic condition. Treatment recommendations for this group were more often drug-related and demanded institutionalization. The younger population received recommendations involving less use of drug therapy and more community-based treatment.

GENERATIONAL DIFFERENCES IN PROBLEM DEFINITION

Another view of underuse of mental health services by the aged is that the elderly are at present reluctant to define their problems in psychological terms (Lawton, 1979). However, an increasing trend toward defining one's mental health problems as such and an increased use of treatment centers has been noted by Kulka and Tamir (1978). They replicated the study of Gurin, Veroff, and Field (1960) on how Americans view their mental health and found that 13% of those 65 and over had actually sought professional help for personal problems. This was a significant increase of 7% over the previous findings. Even more significant, perhaps, was Kulka and Tamir's finding that of the elderly who defined a personal problem in mental health terms 67% had sought professional help. Also suggested was a slight increase in help-seeking attitudes and behavior with age cohorts over time. Thus, it is possible that today's adults between the ages of 20 and 49 (of whom about 44% defined problems in mental health

terms) will be seeking assistance for mental health problems during the later years of their lives, and at a much greater rate than does the current population 65 and above (Kulka & Tamir, 1978). Moreover, this trend should be potentiated due to the current emphasis placed on nonmedical intervention relative to personal problems.

CONCEPTUALIZING PROBLEMS OF THE ELDERLY

It is useful to examine briefly three models used in conceptualizing the problems of the elderly: (1) the social model, (2) the behavioral model, and (3) the medical model. It is the opinion of the authors that these are different but valid and indispensable conceptualizations for dealing with the matter at hand.

THE SOCIAL MODEL

This model attributes the differences between the elderly and younger adults in part to different roles prescribed for these groups by our society. In different societies roles for the elderly may be more or less satisfying. In China, for example, old people are traditionally viewed as being very wise because they have lived very long and are accorded an honored placed in the household and the community. Among the Eskimos, however, old people were formerly sometimes abandoned to die because they were considered useless. Although the United States is a multicultured nation, we generally fall somewhere between the old traditions of the Eskimos and the Chinese in our treatment of our elders.

Although gross generalizations about the treatment of its older population by any pluralistic nation such as ours are inevitably somewhat unfair, it seems to be true that we often expect less responsibility and decreased functional ability on the part of our society's older members. L. M. Miller (1979) proposed three categories of behavior for which we accept lesser levels of functioning from the elderly. These are (1) self-care behavior, or habits related to daily functions such as eating, sleeping, toileting, grooming, and health; (2) task behavior, defined as the management of tasks assigned by membership in specific social groups, including housekeeping and employment responsibilities; and (3) relationship behavior, meaning all kinds of social relationships with other people. According to this view, there is a continuum of behavior within each category. Each continuum runs from those actions which society considers acceptable as part of the normal social role of an old person to those which are considered unacceptable. For example, acceptable relationship behavior demonstrating decreased responsibility is that of elderly parents accepting some control of their affairs by their children. An example of unacceptable relationship behavior would be extreme argumentativeness. Within the category of task behavior, withdrawal from more difficult housekeeping duties is an acceptable form of decreased responsibility and functional status, but unsanitary homemaking is not acceptable. Various changes in self-care behavior are acceptable, including moderate changes in grooming and toileting habits, but incontinence is not.

THE MEDICAL MODEL

The traditional medical model considers deviations from normal functioning as due to illnesses or diseases. These diseases are seen as ultimately caused by improper internal or physiological functioning. External disease-producing factors such as stress, smoking, or improper diet are considered of importance only because they produce improper physiological functioning. Therefore, when confronted with changes in behavior of the elderly, adherents of the medical model seek to find alterations in physiology which produce the changes. For example, changes in the structure and the functioning of the brain are frequently blamed for altered behavior in the elderly.

THE BEHAVIORAL MODEL

The behavioral model seeks to identify, define, and measure behavior with great specificity and to relate the occurrence and nonoccurrence of this behavior to observable *environmental events*. Dependent upon the history and heredity of the individual, different environmental events may prompt, strengthen or weaken, maintain or fail to maintain, behavior of concern. Therefore, when confronted with the problem behavior, the behaviorist seeks to determine events occurring immediately before and after the behavior and to alter these events in order to change the behavior.

THE BEHAVIORAL MODEL IN INTERVENTION WITH THE ELDERLY

A current view of the behavioral model is more appropriately presented as reflecting a general orientation to problem resolution (Goldfried & Davison, 1976; Hersen, 1981; L. M. Miller, 1976) than as simply a compilation of techniques. Thus, the behavioral model represents an empirical approach. Behavior is assessed as lawful and is believed to be a function of specifiable antecedent, (intra)personal, and consequent conditions. Within this framework, treatment strategies are empirically rather than theoretically based, stressing objective, observable assessment, systematic evaluations of outcome, and the use of empirically validated procedures. Thus, the behavior therapist in his or her approach to clinical problems operationally defines the problem behaviors, attempts to measure them reliably, designs interventions specific to the targeted behaviors, and attempts to document objectively any resultant changes in behavior. Such an approach, being problem-oriented rather than age-specific, appears to be applicable to many of the well-documented problems noted in later life (Patterson & Jackson, 1980b). Those behaviors which have been targets of successful modification attempts include daily living skills (behavior necessary for the successful maintenance of one's life on a daily basis), social and leisure activities, social skills (behavior necessary for the development and maintenance of one's social support network), and intellectual performance. In light of this approach it would appear that behavioral techniques have sufficient utility for geriatric populations. Several authors have encouraged the use of behavior therapy relative to problems associated with late life (M. M. Baltes & Barton, 1977; Cautela & Mansfield, 1977; Hoyer, 1973; Hoyer, Mishara, & Reidel, 1975; Lankford & Herman, 1978; Lindsley, 1964; Patterson & Jackson, 1980a,b).

COMPLEMENTARY IMPORTANCE OF THE THREE MODELS

It is very unfortunate that these three models have sometimes been viewed as being in conflict; as if *either* social, medical, or behavioral variables were the true causes of functional changes in older people. It is obvious that changes in all three classes of variables occur throughout the life span. One changes roles from an infant, a preschooler, a schoolchild, an adolescent, a mother, a worker, to a retired or a nonretired elder. These roles (as shared expectancies) have profound effects upon behavior. In addition, there are vast changes in physiological functioning occurring during the life span due to both normal development and various disease processes. Similarly, learning experiences which serve to produce and modify behavior continue throughout life. It is worth stressing that the modification of behavior throughout life because of individual experience is a continuous and natural process which occurs to everyone. New learning, as well as the modification of old learning, is stopped only by death.

Because all three classes of variables change simultaneously throughout life, all three may be considered as causes of changes due to the aging process. This statement may seem in conflict with the topic of this book, a behavioral treatment program for the elderly. Any conflict is only apparent and not real. It is true that the authors *chose* to develop a treatment program that concentrates on behavioral interventions, but this choice was not intended to imply that variables which are properly the subject matter of medical and sociological science are not of importance.

Gerontology has been heavily dominated by input from sociology, medicine, and developmental psychology. However, with regard to effective therapeutic intervention, Kastenbaum (1968) noted that psychologists had contributed very little to the welfare of the aged beyong "counting their wrinkles." Patterson and Jackson (1980a) reviewed the literature regarding behavior modification and the elderly and found a paucity of *well-developed* interventions, although almost all the behavioral research supports the plasticity of the behavior of the elderly. The field of actively applied, programmatic approaches to the use of behavioral procedures relative to the enhanced welfare of the aged would seem to be an almost open one, particularly concerning the elderly residing in the community.

In order to understand this lack of application of behavioral approaches, it is useful to examine the difference between historical causation of behavior and interventions to change existing behavior. It is unfortunately true that medical model approaches have sometimes been misused to lead to a dead end when applied to the functioning of the elderly. Adherents of the medical model have sometimes seemed to take the approach that because nothing could be done to cure the basic physiological changes of aging, nothing useful could be done to alleviate most age-related problem behavior until such time as appropriate cures were developed. This situation was particularly true with regard to functional changes assumed to be caused by alterations in the brain. Clearly, this is a misuse of the medical model, but it is a misuse which the authors have found to be dismayingly prevalent. A more proper use of the medical model would be to continue to encourage medical research regarding the physiological changes related to aging, while *also* recognizing and actively encouraging research and application of social and behavioral methods.

Students of the social model have studied various social situations and have determined that some may be valued as better than others with regard to promoting the well-being of the elderly. Some have even advocated the development of specific types of residential arrangements for this purpose. As valid as such interventions may be, they require large-scale, expensive developments which can be applicable to only a very few persons in the near future. Furthermore, rearranging communities is not likely to remediate totally the problems of any individual. It is probable that even if every elderly person in the United States were transported to some type of ideal community, there would still be great need for individual intervention to improve many types of problem situations. In addition, it can be debated that this type of approach does not really remedy problems, but instead may actually *discourage* remediation by providing compensations for problems rather than seeking to overcome them.

Some advantages of including behavioral approaches to interventions with problems of the elderly will now be discussed. It is important to note that what is advocated is that appropriate behavioral interventions be used concurrently with the best medical and social interventions available. The addition of behavioral interventions and concepts is of great importance because too many efforts in the past have included only medical and social approaches. The first advantage to be considered will be that of overcoming an unfortunate discriminatory attitude toward the elderly which has existed in this country.

SPECIFIC BENEFITS OF THE BEHAVIORAL MODEL TO THE ELDERLY

Ageism is pervasive, and any model of intervention which intentionally or otherwise places primary or sole focus on the age of a person is susceptible to its intrusion. The tendency is to accept behavioral change as a one-to-one correlate of physical change; yet such an age/behavior correlation is quite arbitrary (M. M. Baltes & Barton, 1977). Such purported correlations, when maintained either by a culture or treatment model (either explicitly or implicitly) affect the expectations of the targeted age group as well as those attending to them. Thus, an important value of the behavioral approach is as a means of avoiding the negative impact of cultural expectations and allowing the treatment specialist to focus on the task at hand: the resolution of problem behavior regardless of the age of the client. The behavioral model minimizes the encroachment of ageism on treatment programs.

Within the behavioral model, an older person's physical changes and existing illnesses (if any) are not considered as the sole cause of behavior; also to be taken into account are the changes in the environment. This directs the behavior therapist to consider factors other than age and physiological changes as the bases of behavior and

BEST COPY AVAILABLE

limits the probability of the intrusion of ageism with its negative attitudes (particularly relative to the reversibility of behavior). Support for the reversibility of (functional) age decrements, as well as the reversibility of apparent cognitive impairment, has been reported in reviews of the literature by Baltes and Barton (1977) and Patterson and Jackson (1980a,b).

The literature dealing with the direct modification of problem behavior associated with later life supports the viewpoint that behavior is a result of the interaction of organismic variables with environmental variables and that the interaction of changes in the internal and external variables produces behavioral changes (M. M. Baltes & P. B. Baltes, 1977; M. M. Baltes & Barton, 1977; P. B. Baltes & Willis, 1977; Hoyer *et al.*, 1975; Patterson & Jackson, 1980a,b; Rebok & Hoyer, 1977). Prior to this behavioral view, physiological changes were given undue emphasis as the bases for changes in behavior. More will be said regarding the interaction of variables later in the chapter.

In directing treatment specialists to consider factors other than age, the behavioral model permits, if it does not prompt, an optimistic attitude regarding the mental health problems of older people. Rebok and Hoyer (1977) state that, notwithstanding such labels as senility and organic brain syndrome, the behavior therapist proceeds to ascertain the extent to which a particular behavior can be remedied. Problems are defined in terms of occurring behavior, and are treated on the assumption that they can be remedied.

The heterogeneity/variability of the aged is not lost in the behavioral approach to problem behavior. The design of an appropriate treatment plan within the operant model usually requires that the treatment specialist establish appropriate antecedent conditions and reinforcers for behavior change. The individualized plans are monitored for efficacy on an ongoing basis. As a group, the elderly may be more heterogeneous in their behavior, as well as in the bases for the behavior, than any other group; and this variability can be taken into account by the treatment specialist through individualized treatment plans (Hoyer, 1974; Rebok & Hoyer, 1977). Such an approach promotes successful intervention with older individuals either for prevention, maintenance, or rehabilitation (Hoyer, 1973, 1974).

Cautela and Mansfield (1977) have also noted the specific value of the behavioral model to the problem behavior of the elderly: (1) time is not unnecessarily spent on determining the "true" impact of all past life experience, (2) present behavior is the target for change (rather than seeking some unconscious motivator of behavior), (3) older individuals profit more from active therapists and treatment involving problem-oriented behavior rehearsal (as opposed to the

more passive insight therapy), and (4) no attempts are made to apply negative diagnostic labels. Labels are rarely removed, and usually once designated no attempt is made to change the behavior. However, "even when organic dysfunction is noted it can be of practical value to assume that many behaviors can be modified somewhat by applying specific behavior therapy procedures regardless of past history or organic involvement" (Cautela & Mansfield, 1977, p. 23). Also, the notion of behavioral inflexibility often attributed to the elderly becomes an empirical question rather than a "fact" based upon sociocultural attributions relative to old age. Such an empirical approach has resulted in doubts as to the general validity of a biological decrement model and given a better accounting of problem behavior in old age in terms of the interaction of organismic (e.g., biological) and environmental determinants (Baltes & Baltes, 1977; Baltes & Barton, 1977; Baltes & Willis, 1977). Baltes and Burton (1977) report findings challenging many of the neurophysiological explanations for "older behavior" in the area of intellectual/cognitive behavior and also report on studies demonstrating that various patterns of behavior thought to be irreversible and a result of some disease process can be positively altered by means of contingency management. Such change was the result of the rearrangement of events antecedent to and consequent to the occurrence of behaviors. Other behaviors thought to be age-related were also positively altered by operant procedures. These included reversal of social isolation, increasing interest in one's environment, reversal of poor hygiene and grooming habits, modification of self-injurious behavior, and increased social and verbal behavior (Baltes & Barton, 1977).

Another value of the behavioral approach is that self-management or control can be augmented. The initial therapist can be faded, further enhancing independence. Individuals of all ages can be taught behavior analysis (identification of antecedents and consequences to behavior) and how to implement change and maintenance procedures. Also, teaching elderly individuals to shape and control actively those parts of their environment contributing to functional as well as dysfunctional behavior increases their belief in personal efficacy. Thus, the elderly can be taught to attribute through behavior analysis the basis of problem behavior to the appropriate sources: organismic, environmental, or both. By more accurately attributing responsibility for behavioral events, rather than invoking some global concept referred to as the *aging process*, dysfunctional behavior is seen as less inevitable and remediation or prevention more likely. Rodin and Langer (1980) point out that overattribution to aging rather than to remedial sources, in conjunction with a negative labeling process apparent in our culture relative to the elderly, generates decreased self-esteem and diminishes performance. Over time, and with disuse, the abilities themselves may also decline (Langer, Rodin, Beck, Weinman, & Spitzer, 1979; Rodin & Langer, 1980). To reverse these effects, older people might be encouraged to attribute responsibility for behavior to the more appropriate source rather than attributing consequences in a manner consistent with cultural stereotypes. By doing so, many supposed irreversible and age-determined behaviors can be remedied.

The behavioral model is also useful in the treatment of older individuals in terms of cost effectiveness, the replicability and/or consistency of treatment, the value of negative results as well as positive, the structure afforded staff in attending to individuals in treatment, and suitable community placement based upon individual circumstances. Often the resources for treatment are scarce, and behavioral treatment programs in diverse settings have successfully used paraprofessional staff (Rebok & Hoyer, 1977), as well as employing the rearrangement of existing resources rather than adding new ones (Patterson & Jackson, 1980a,b). In many treatment programs there is a lack of consistency of treatment application or a lack of quality control (Hersen, 1981). Within the behavioral model, fairly detailed treatment manuals can be made available so as to minimize the personalization of a treatment approach by the various therapists in the setting. Such standardization procedures also help prompt the treatment specialists to maintain their active participation and modeling rather than allowing treatment to drift toward approaches reflecting more cognitive and passive attitudes. Thus, the value of behavior therapy to any treatment program is a sense of quality control including treatment stability over time and replicability both within and without the program.

Replicability of treatment results is also a goal of the behavioral model. Obviously replicability of positive results is valuable, but so too is replicability of negative results (Rebok & Hoyer, 1977): "Negative results are important because they often suggest procedures that are ineffective or harmful" (p. 32). Another value of operant-based intervention is that it requires observation on the part of those who are involved in the treatment plan. The attention of the staff and others is intentionally directed toward the individuals' behavior. By using structured intervention approaches (e.g., a token economy system) and basic learning principles, treatment specialists can be "forced" to attend to desired (targeted) behaviors and then function as both providers of tokens and social reinforcers. Richards and Thorpe (1978) also report studies in which behavioral techniques were successfully applied to the behavior and attitudes of treatment staff caring for elderly in institutional settings.

Lastly, the precision or clarity of most information produced in treatment programs emphasizing the behavioral model also is valuable relative to client placement. For example, if an individual does not know *what* medications to take *when*, and even with continued training and assessment never significantly improves over baseline, then placement for such an individual should incorporate the behavioral data relative to medication. The community placement setting should provide enough structure and/or assistance to ensure that all who require medication are prompted to take it properly.

This chapter has thus far emphasized the benefits and appropriateness of the use of the behavioral model in the treatment of elderly clients. To follow is a presentation of how these potential benefits assisted in the formulation and direction of the clinical intervention approaches of the Gerontology Program at the Florida Mental Health Institute.

BEHAVIORAL INTERVENTION WITH THE ELDERLY AT FMHI

An underlying premise of the Gerontology Program is that older adults who are suffering from behavioral deficits and/or personal and social losses can learn or relearn skills to overcome these deficiencies. Three major problems often associated with later life are attended to: (1) skill deficits, when older individuals have discontinued taking care of themselves; (2) psychosocial losses, when there is a loss of the significant interactions with others which serve to maintain mental health in general; and (3) the occurrence of inappropriate or excessive behavior which is sometimes a result of the other two factors. Even though the approach is problem-oriented (rather than age-oriented), an emphasis is placed on acquisition of skills that lead to increased self-enhancement, self-control, and self-management. Thus, in contrast to a debilitation or decline model of aging, attempts are made to foster self-improvement and self-maintenance.

A number of reviews dealing with the direct modification of problem behavior in the elderly support the viewpoint that such behavior is the result of interaction of organismic (people) variables with environmental variables (Patterson & Jackson, 1980a). Many instances of behavioral deficits are determined to be promoted by the environment and/or the lack of encouragement (prompts and reinforcers) from the environment for the desired, more functional behavior. This research-founded conclusion is the basis of the Gerontology Program's approach in treating older individuals. Thus, in agreement with Goldfried and Davison (1976), whether a client engages in certain behavior is believed to depend not only on the availability of the behavior within the individual's response repertoire, but also upon the degree to which certain environmental determinants elicit and/or reinforce the designated behavior. The application of the antecedent-behavior–consequence (ABC) analysis of behavior paradigm has proved to be very useful with the elderly. Baltes and Barton (1977) and Patterson and Jackson (1980b) cite numerous studies detailing the impact of poor environmental living conditions in age-performance decrements, particularly as the environment interacts with changing biological processes. Such findings seem to suggest that not only should the traditional (ABC) analysis of behavior be used with the elderly, but that such an analysis should heavily incorporate as interaction variables those deficits associated with aging (Patterson & Jackson, 1980b). Deficits associated with aging (such as those of vision, hearing, or memory) interact with environmental antecedent and consequent events so as potentially to decrease the effectiveness of those events on the acquisition and maintenance of desired behavior and/or on the reduction of dysfunctional behavior.

The Gerontology Program staff have noted a major difference in the application of behavioral procedures with different age populations (e.g., children versus elderly). With young populations, behavioral intervention is more often used to establish new behavior; whereas with the elderly behavioral procedures are more often used to reestablish responses to an appropriate strength and/or frequency. Thus, the elderly are more likely to have the target behavior within their response repertoire, and very often minimal prompting initiates quick, if not almost spontaneous, recovery of such behavior (Patterson & Jackson, 1980b). However, the maintenance of such behavior must be carefully considered. The behavioral approach relative to the elderly certainly removes the mystery from how to go about eliciting appropriate behaviors, how to maintain them, and how to eliminate dysfunctional behaviors. Nothing works as simply as stated, but the process is understandable (to both client and treatment specialist) and replicable.

Lastly, it would appear that the major factors in aging-related behavior are disuse, sparsity, and expectancies (Baltes & Barton, 1977). When performance deterioration through disuse (in combination with a sparsity of environmental reinforcers and cues) interacts with the negative cognitions (expectancies/prophecies) held by older

people, response decrements are further augmented. The behavioral model is appropriate to the alteration of any of these factors; disuse, sparsity, expectancies. Because of this, the Gerontology Program incorporated the behavioral model in its treatment program in the belief that behavior therapy, when viewed as an integrated approach to problem behavior, would provide the most effective and workable framework both for the elderly and for the treatment staff.

The section in the text on barriers lends itself very easily to group discussion. Emphasize the impact that agism can have onthe referral and treatment of clients. This is a good point at which to talk about some of the myths and stereotypes about the elderly that color our thinking. Some of the more common stereotypes about the elderly are:

1) All old people are alike.
2) Old people are too set in their ways to change.
3) Old people can't cope with problems
4) All old people become depressed, it's normal at that point in their lives.
5) It is normal for older people to be confused most of the time.
6) Old people cannot learn new things---You can't teach an old dog new tricks!!! Right?
7) It is a waste of time and money to attempt mental health interventions with elderly clients.

Give each student a copy of the discussion guide. Ask them to silently list items that they feel prevent older clients from using mental health services. As mentioned in the text, these barriers can stem from the client, the aging services staff and/or the mental health providing staff and from the program design or regulations.

After everyone has finished writing their list, go around the room and ask each person to tell the class one of the barriers on their list. This can be continued until everyone passes. This list can be the basis for class discussion. Which barriers on the list could be solved? How could a solution be implemented? How much would the solution cost? Could it be solved within available resources? Who would have to be involved?

BLANK PAGE

DISCUSSION GUIDE

BARRIERS TO THE UTILIZATION OF MENTAL HEALTH SERVICES BY THE ELDERLY

Use the following form to list the barriers to the utilization of mental health services by the elderly -- client-related, staff-related and program-related, (e.g., gaps in service, eligibility criteria, transportation and policies and procedures, etc.) Keep in mind the text and what it says about barriers and the client-staff-program categorization.

CLIENT-RELATED BARRIERS

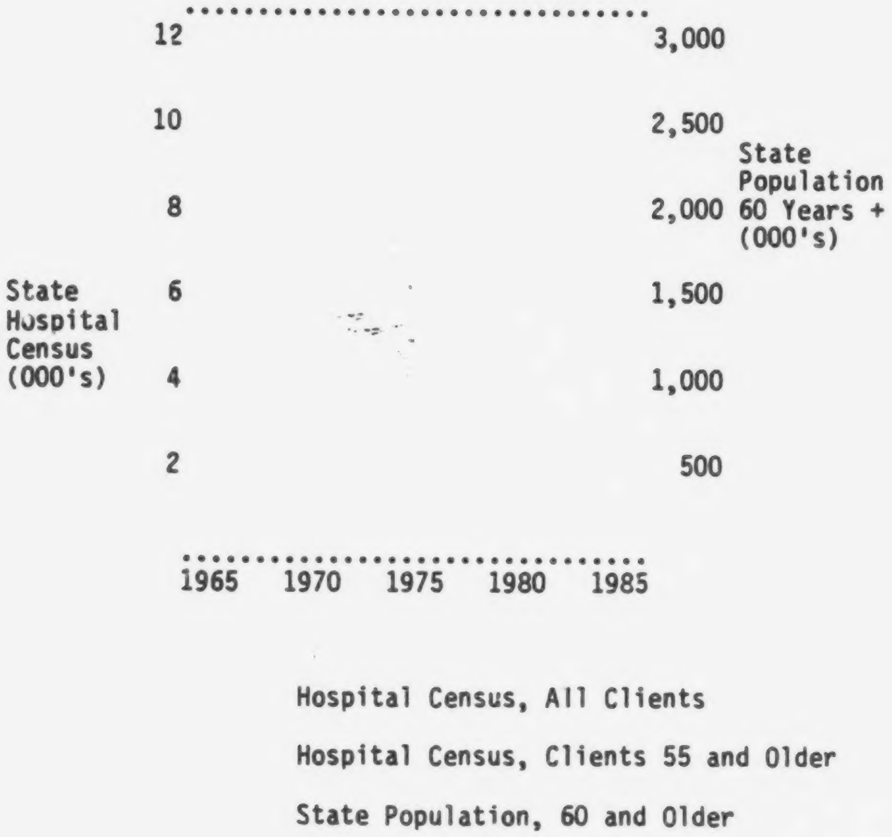
STAFF-RELATED BARRIERS

PROGRAM-RELATED BARRIERS

BLANK PAGE

Viewgraph #1

FLORIDA STATE HOSPITAL CENSUS AND STATE POPULATION
1965-1985



BEST COPY AVAILABLE

BLANK PAGE

Viewgraph #2

MENTAL HEALTH SERVICES FOR THE ELDERLY

AOA TRAINING GRANT

INCIDENCE OF MENTAL HEALTH PROBLEMS AMONG THE ELDERLY

NATIONAL:

PRESIDENT'S COMMISSION ON MENTAL HEALTH 1981:
15-25% OF THE ELDERY SUFFER FROM M.H. PROBLEMS.

NATIONAL INSTITUTE OF MENTAL HEALTH:
58% NURS. HOME CLIENTS HAVE CHRONIC MENTAL ILLNESS.

25% OF SUICIDES ARE COMMITTED BY PERSONS OVER AGE 60.

GENERAL ACCOUNTING OFFICE (1982): ". . .THE MENTAL HEALTH NEEDS OF THE ELDERLY ARE NOT ADEQUATELY ADDRESSED BY COMMUNITY M.H. CENTERS, NURSING HOMES, AND OTHER PROVIDERS. OLDER PERSONS REMAIN DISPROPORTIONATELY UNDERSERVED IN THE COMMUNITY . . ." THE MOST FREQUENT PROBLEMS ARE "1) ACUTE ANXIETY AND DEPRESSION; 2) CHRONIC DEPRESSION, SCHIZONPHRENIA AND TRADITIONAL ILLNESSES, AND 3) TRUE DEMENTIA AND PSEUDO DEMNTIA . . ."

THE ELDERLY REPRESENT 3-7% OF CMHC CASELOADS ALTHOUGH BEING 11% OF THE POPULATION

BLANK PAGE

Viewgraph #3

MENTAL HEALTH SERVICES FOR THE ELDERLY

AOA TRAINING GRANT

INCIDENCE OF MENTAL HEALTH PROBLEMS AMONG THE ELDERLY

FLORIDA:

DHRS STUDY (1981) OF NURSING HOMES:

38% CONFUSED
18% FORGETFUL
23% DISORIENTED
30% SEVERELY CONFUSED
2% COMATOSE; NONRESPONSIVE
34% CHRONIC O.B.S. ADMITTING DIAGNOSIS

DHRS STUDY (1986) OF COMMUNITY MENTAL HEALTH SERVICES

STATEWIDE: 28.9% OF POPULATION 55+

17.3% OF CMHC EXPENDITURES

2.3% OF 55+ POPULATION

DIST. VI: 25.2% OF POPULATION 55+

12.5% OF CMHC EXPENDITURES

0.8% OF 55+ POPULATION

BLANK PAGE

Viewgraph #4

STATISTICAL REPORT OF HOSPITALS

FLORIDA STATE HOSPITALS, JUNE 30 CENSUS

YEAR	TOTAL	55-64	65-74	75 & +	TOTAL 55+	PER CENT
1963	9822	2000	1464	1224	4688	47.8
1964	9986	2057	1457	1300	4821	48.3
1965	9992	2046	1525	1294	4865	48.7
1966	9855	2110	1583	1397	4990	50.6
1967	9905	2081	1589	1321	4991	50.4
1968	9603	2110	1583	1266	4957	51.6
1969	9656	1962	1696	1295	4953	51.3
1970	9271	1892	1449	1154	4495	48.5
1971	8873	1843	1328	1006	4177	47.1
1972	8170	1662	1343	1067	4072	49.8
1973	6857	1369	1242	979	3590	52.4
1974	6365	1211	1065	901	3177	49.9
1975	6244	1016	935	838	2789	44.7
1976	5836	864	847	821	2532	43.4
1977	5887	873	820	840	2533	43.0
1978	5673	808	765	780	2353	41.5
1979	5393	732	737	745	2214	41.1
1980	5071	646	663	723	2032	40.1
1980	5071	646	663	723	2032	40.1
1981	4875	616	669	754	2039	41.8
1982	4320	505	584	664	1753	40.6
1983	3757	NA	NA	NA	1378	36.7
1984	3530	NA	NA	NA	1163	33.0
1985	3400	NA	NA	NA	989	29.1

BLANK PAGE

Viewgraph #5

STATISTICAL REPORT OF ADAMH-PD, 1982-1983

I. BAKER ACT ADMISSIONS

	State Total	HRS District 6
Total Admissions	19,602	1,689
55 Years & Older	1,220	103

II. COMMUNITY MENTAL HEALTH CENTER CASELOAD

	State Total	HRS District 6
7/1/82	85,950	5,715
6/30/83	86,766	5,199
Race/100,000 pop.	903	813

BLANK PAGE

Viewgraph #6

STATISTICAL REPORT OF ADAMH-PD, 1982-1983

BAKER ACT ADMISSIONS

	STATE TOTAL	HRS DISTRICT 6
TOTAL ADMISSIONS	19,602	1,689
55 YEARS & OLDER	1,220	103
55+ PER CENT	6.2%	6.1%

COMMUNITY MENTAL HEALTH CENTER CASELOAD

	STATE TOTAL	HRS DISTRICT 6
7/1/82	85,950	5,715
6/30/83	86,756	6,199
PER CENT TOTAL POP.	0.9%	0.8%

DHRS 1985 SURVEY OF CMHC SERVICES FOR ELDERLY

	STATE TOTAL	HRS DISTRICT 6
PER CENT POP. 55+	28.9%	25.2%
PER CENT CMHC $	17.3%	12.5%
PER CENT 55+ SERVED	2.3%	0.8%

BEST COPY AVAILABLE

BLANK PAGE

MENTAL HEALTH SERVICES

Name: ______________________________ Date: ________________

CIRCLE THE CORRECT ANSWER.

1. Those 55 years of age and older represent approximately 25% of Florida's population and account for approximately ________ per cent of the caseload of community mental health centers.

   a. less than 5%
   b. about 15%
   c. more than 25%

2. Most of the elderly who are institutionalized for mental health reasons are institutionalized in:

   a. state hospitals
   b. private hospitals
   c. nursing Homes

3. The prevalence of Alzheimer's disease and related disorders among people age 65 and above is reportedly:

   a. about 5%
   b. about 15%
   c. about 25%

4. Although they constitute only 11% of the U.S. population (1980 Census), persons aged 65 years and older accounted for __________ per cent of the reported suicides:

   a. 5%
   b. 15%
   c. 25%

5. A common staff barrier to the delivery of mental health services to the elderly is professional ageism, and this is attributed primarily to:

   a. lack of appropriate education and training concerning the elderly
   b. personal fear of aging and denial of aging among practitioners
   c. unresolved guilt about relationship with own parents

6. Mental health services are:

   a. restricted to those with a diagnosed psychiatric problem
   b. for those with problems in living
   c. available only in hospitals

7. In Florida the number of elderly in the State hospitals has ________________ the growth of the elderly population in the State.

a. kept pace with
b. grown well beyond
c. dropped below

8. In general in the U.S. and in Florida, the elderly are ____________________ in the mental health caseload.

a. under-represented
b. proportionately represented
c. over-represented

9. As people mature and grow older their need for mental health support:

a. decreases
b. remains the same
c. increases

10. Many of the mental health problems of the elderly develop from:

a. infectious diseases
b. senilty
c. social interactions

Mental Health Services

1. b
2. c
3. a
4. c
5. a
6. b
7. c
8. a
9. c
10. c

BLANK PAGE

ELDERLY RESIDENTIAL CLIENTS

G. PIERCE WOOD MEMORIAL HOSPITAL

I. INTRODUCTION

To obtain guidance in planning future residential treatment, training and research projects, the Gerontology Program at the Florida Mental Health Institute (FMHI) conducted a study of certain clients at G. Pierce Wood Memorial Hospital (GPWMH) during June and July, 1981. This report summarizes the data obtained, the findings discovered, and the conclusions reached about this particular population of mental health clients 55 years of age and older.

The first section of the report presents the specific questions being addressed, and reviews the procedures that were followed to obtain the data base to answer these questions. The second section of the report presents the findings in a series of tables that summarize the data along particular parameters of interest:

Table I	Demographic Characteristics
Table II	Referral Data
Table III	Admission Data
Table IV	Hospitalization Record
Table V	Characteristics by County of Residence
Table VI	Characteristics by Length of Hospitalization
Table VII	Behavioral, Medical and Skill Status
Table VIII	Five Year Admission and Census Trends

Appendices contain the forms that were used to collect the data; the codebook for computer entry and printout interpretation; and a summary of the data on Gerontology Program residential clients. The final section of the report presents the inferences that can be drawn from the data as related to sex, county of residence, and length of hospitalization; the significance of the five year changes in census and admissions; and the conclusions for residential project planning.

II. QUESTIONS AND DATA BASE

Objectives and Planning Questions

The objectives of the study were to collect and analyse data on elderly clients at GPWMH, and to draw conclusion from these analyses that would be useful in planning residential projects at FMHI. More specifically, the study was directed to answering the following five sets of questions:

- How many elderly clients are there at GPWMH, and who are they?
- Where do these clients come from, how were they referred, and why were they admitted?
- How long have they been hospitalized at GPWMH, and why are they still hospitalized?
- Are Gerontology Residential clients representative of the GPWMH elderly population?
- Are the GPWMH clients uniformly distributed along variables, or are there discontinuities or bimodal distributions that differentiate the client population into separate categories?

The answers to these questions should provide guidance for developing strategies not only for deinstitutionalization projects but also for intervention prior to hospitalization.

Six County Area

In general the study focused on those clients who were admitted from, or residents of, a six county area (Hillsborough, Manatee, Pinellas, Pasco, Polk, and Sarasota) since a survey of all elderly patients at GPWMH was beyond the capabilities of the Gerontology Program. These counties comprise a "natural" catchment area for FMHI; most Gerontology Program residential clients (88.2%) have been admitted from them; and they provide a data base directly related to the two Geriatric Residential Treatment System projects in Manatee/Sarasota and Pinellas/Pasco.

The Survey

The Medical Records Department at GPWMH prepared a list of all patients 55 years of age and older from the six county area. The records of these 256 patients were reviewed at GPWMH on June 9 and 10 by staff of the Gerontology Program. Biographic, demographic, and psychiatric hospitalization data were extracted and entered onto forms previously prepared at FMHI (Appendix A). From these forms, IBM code sheets were prepared, cards punched, and the data entered on file at the USF Data Center. Computer printouts were obtained giving frequency distributions or categorical proportions on all variables. The codebook for all data, including definitions of variables, appears in Appendix D.

IV. CENSUS AND ADMISSION, 1975 - 1980

In planning treatment programs, especially those which are to be demonstration projects, consideration should be given not only to the target population as it exists today, but also to how the target population may be changing or is likely to change over the anticipated lifetime of the projected research/demonstration project. For this reason a retrospective analysis of the census and admission of the elderly patient population at GPWMH has been conducted, believing that trends of the past may be extrapolated into the future. GPWMH census and admissions for the fiscal years 1974-1975 and 1979-1980 (the most recent report available) are presented in Table VIII.

These data clearly indicate that there has been an appreciable decline in both admissions and census at GPWMH for patients from the six county area. Patients from Hillsborough County that were admitted to Northeast Florida State Hospital during Fiscal Year 1979-1980 have been added to GPWMH so that there is not the bias due to change in catchment areas. Similarly, Hillsborough patients on the census of NFSH at June 30, 1980 were also included in the Table VIII tabulation of elderly clients.

Admission of all ages dropped, with the total showing a 33% decline over the five year period or an average of 6.6% per year. The absolute decline in admissions dropped by 505 or more than 100 per year. For elderly clients the reduction in admissions was less than for total admissions, being only 21% or 4.2% per year. For some counties the decline in admissions of elderly patients matched the decline in total admissions. This was not true for Hillsborough, which remained fairly consistent over the five year period, nor for Manatee, where there was actually an increase in the number of admissions (5% or 1% per year). The absolute decline in admissions of 64 or about 13 per year does not seem great, yet it must be remembered that during this same period there was a significant increase in the elderly population, particularly in Manatee, Sarasota, and Pinellas, so that the admission rate per 100,000 population has decreased a very substantial amount.

Across the six county area, the census has also dropped, but only by 11% for the five year period or at an annual rate of 2.2%. The drop has not been uniform by county with both Manatee and Sarasota showing an increase over the five year period. As a percentage of the total GPWMH elderly patient population, the patients of the six county area have increased from 67% to 79% (including the Hillsborough County residents at NFSH. This is in part the reason for the transfer of catchment area).

TABLE VIII

COMPARATIVE ADMISSIONS AND CENSUS BY COUNTY
GPWMH, FISCAL YEAR 1975 -vs- FISCAL YEAR 1980

	7/1/74 - 6/30/75	7/1/79 - 6/30/80	% CHANGE
TOTAL ADMISSIONS (All Ages of Clients)			
Hillsborough	481	273*	-43%
Manatee	154	147	-5%
Pinellas	414	281	-32%
Pasco	57	4	-93%
Polk	199	153	-23%
Sarasota	205	147	-28%
TOTAL	1,510	1,005	-33%
ESTIMATED ADMISSIONS 55+			
Hillsborough	46	45*	-2%
Manatee	40	42	+5%
Pinellas	109	79	-28%
Pasco	16	1	-94%
Polk	25	20	-20%
Sarasota	62	47	-24%
TOTAL	298	234	-21%
ESTIMATED CENSUS 55+	AT 6/30/75	AT 6/30/80	
Hillsborough	76	73*	-4%
Manatee	41	58	+41%
Pinellas	142	109	-23%
Pasco	22	4	-82%
Polk	52	42	-19%
Sarasota	60	64	+7%
SIX COUNTY TOTAL	393	350	-11%
TOTAL GPWMH, 55+	587	443	-25%

*Includes admissions and census at NFSH since Hillsborough was placed in NFSH catchment area during 1980.

The significance of the differential rates of decline between admissions and census, admission decline being half again as much as census decline, is that the ratio of long term to short term clients is increasing. If the same average annual reductions are projected linearly into the future, by June of 1984, GPWMH would no longer admit any elderly clients from the six county area except for Manatee. On the other hand, the elderly patient census for the six county area would be about 315. In effect, GPWMH would have become a long term care nursing home.

An earlier study of certain GPWMH elderly clients conducted in 1979 disclosed a lower average age and a lower incidence of O.B.S. than the current sample of 256. Although there are certain methodological differences in the selection of the two samples which may bias the comparative results, it would appear that the elderly population of GPWMH patients is becoming more and more like a long term care, nursing home population as opposed to a population of a treatment and rehabilitation hospital. One of the reasons for this may in fact be the impact of the Gerontology Program on the State hospital and community treatment programs. First, the Gerontology Residential Project has taken 113 clients from GPWMH and the majority of these have been placed back into the community with apparently low recidivism rates. This is a significant number when one considers that during the same five year period the total drop in GPWMH elderly census was only 43. Secondly, the Gerontology Program has assisted in the implementation of deinstitutionalization projects at three of the State hospitals, including GPWMH, and community projects in Manatee, Pinellas, and Santa Rosa counties. In fact, there is now competition among these various groups for the elderly clients who hold promise for rehabilitation. To the extent that these projects continue to be successful, there may not be for long an elderly population in the State hospitals that is medically stable, competent, can function in an open setting, and whose principle problems are dependency and a lack of social and ADL skills.

V. SUMMARY AND CONCLUSIONS

Answers to Questions

This report started by asking five series of questions concerning the population of elderly patients at GPWMH from a six county area. Answers to these questions provide a summary of the findings:

- How many elderly clients are there at GPWMH, and who are they?

  There are 256 patients from the six county area and they are described in Tables I, II, III and IV. Their average age is 71.4 years, 58.6%

are female, and 38.7% are married. 57% were readmissions, and their average prior hospitalization was 26.8 months.

- Where do these clients come from, how were they referred, and why were they admitted?

One-quarter of the patients come from Manatee County with the others being fairly evenly distributed among Hillsborough, Pinellas, Polk and Sarasota counties. Pasco has only one patient at GPWMH. Records indicate only 39.5% are referred by CMHC's but 75.1% are transferred from either general or psychiatric hospitals, presumably Baker Act Receiving Facilities.

The most frequent reason for admission was "Confusion" and the most common secondary reason was "Aggression." 64.5% were diagnosed as "Psychotic" on admission and 62.9% were diagnosed as O.B.S. Only 4.3% had neither diagnosis. 74.2% were involuntary patients, and 26.6% were adjudicated as incompetent.

- How long have they been hospitalized at GPWMH, and why are they still hospitalized?

The average length of hospitalization for the current admission is 50.1 months. This is misleading because the range of hospitalization is from less than one month to 627 months. The median is a little less than two years. 160 of the 256 sampled have been hospitalized for twelve months or more. 30 patients or approximately 12% have been hospitalized for three months or less. The main behavioral reason for continued hospitalization is "Confusion" with disorientation to time and place as the most common (52%) medical reason. 50% of the sample have some medical problem which requires treatment apart from psychiatric, psychological, or behavioral problems. Lack of social skills and ADL deficits also are common among the patients.

- Are Gerontology Residential clients representative of the GPWMH elderly population?

  The two populations are quite different along some of the variables. Demographically, Gerontology clients are younger, less likely to be married, more likely to be female, and much more likely to be residents of Hillsborough and Pinellas counties. Fewer Gerontology clients are diagnosed as O.B.S. and much fewer are adjudicated incompetent, but almost all are voluntary patients. Most Gerontology clients have previous psychiatric hospitalization (only 4.4% first admissions) and their average prior period of hospitalization is nearly three times the GPWMH patient average.

- Are the GPWMH patients uniformly distributed... or can they be differentiated into separate categories?

  The GPWMH patient sample differs along at least three of the variables examined: sex, county of residence, and length of hospitalization. It would appear that there are significant differences in terms of reasons for hospitalization, social support system, and length of stay between males and females. Likewise there are differences in the types of clients being referred to GPWMH by the different counties with Manatee/Sarasota showing one pattern and Pinellas/Hillsborough another. Finally, it would appear that there is a difference by length of stay into a short term, high turnover group and a long term, chronic group.

Conclusions for Planning

The objectives of the study, as stated in the introduction of this report, were to obtain guidance for planning future residential treatment, training and research projects for the Gerontology Program. What conclusions do the findings and the answers to the questions provide as input to planning processes?

First it seems quite obvious that the existing Gerontology Residential Project does not serve the same population as GPWMH. It serves only a portion of the GPWMH population, namely that portion which has a history of prior psychiatric hospitalization and which is competent, continent, and medically stable. Hence, the Gerontology population is younger, healthier, voluntary, and shows a lower incidence of O.B.S. This is the specific population which the Gerontology Program was directed to address; elderly, institutionalized patients who were medically stable and not in need of skilled nursing care but possibly could be rehabilitated and placed in less restrictive community settings.

The GPWMH patient population has at least two other groups which are not served by the current Gerontology Residential Project. First is the group of chronics who do not meet the medical, competency or continency criteria. As discussed in the previous section it is expected that this group will grow as a percentage of the hospitalized elderly. If the Gerontology Program is to serve the State Mental Health Facility (SMHF) system, this category of elderly client should be considered as a high priority target population. It might be called the "nursing home" population and planning for such a group will require consideration of increased medical expense, increased staff, and facility expenditures that will bring in-patient space up to nursing home standards.

The second group at GPWMH not now addressed by Gerontology is the short term, non-chronic group. These may be characterized as the "Acute, First-Onset" population. Quantitatively these patients probably represent the largest category being processed through the Baker Act Receiving Centers and GPWMH though due to high turnover rates they do not represent the largest percentage of the elderly census at any particular time. Should the Gerontology Residential Program wish to address this group, referral and access should be prior to transfer to GPWMH with intervention occuring at the Receiving Centers. A treatment program for this group will entail probably a more secure facility and greater medical and psychopharmacological emphasis, both involving higher staff costs and operating expenses.

The differences between the Hillsborough/Pinellas population and that of Manatee/Sarasota raises some interesting speculation. The latter group may be representative of a "healthy and wealthy" retirement population, the married immigrants who have sufficient resources and enjoy good enough health to retire to Florida's Suncoast. (Elderly widows, impecunious retirees, and senior citizens in poor health do not tend to retire to Florida's West Coast.) After ten to fifteen years they may have exhausted their resources or their health or both, experienced some particularly stressful event, and had an acute emotional or behavioral episode. Such a scenario would explain the higher age, the higher marriage percentage, the preponderance of first admissions, and the shorter periods of hospitalization. This group is in contrast to the Hillsborough/Pinellas "working" natives who have just grown older without any of the dislocations associated with retirement to a different geographical area, and whose psychiatric hospitalization histories often pre-date retirement age. Are the treatment needs of the two populations different? Is the older, more married, first-onset, short stay group from Manatee/Sarasota really behaviorally, socially, and psychiatrically different from the younger, widowed-divorced, long-stay repeaters from Pinellas/Hillsborough? If so, should the former group be addressed by the Gerontology Program? If the scenario is true, we can expect this group to increase substantially not only as retiree immigration continues to increase but as the large number of retirees of the seventies and eighties begin to experience acute episodes. A more complete inspection of this "retiree" population at Manatee and Sarasota Receiving Centers is necessary either to validate or to reject the scenario and to gain insight into treatment needs should this specialized population exist.

In conclusion, it would appear that the present population being addressed by the Gerontology Residential Project is representative of only a portion of the elderly population being served by SMHFs. Further, the population being addressed may be declining relative to at least three other groups that can be postulated as utilizing GPWMH, namely:

- o Acute First-Onset
- o Chronic, Long-term, "Nursing Home"
- o Manatee/Sarasota, "Health and Wealthy" Retirees.

To plan and implement demonstration treatment, research and training projects that will address any or all of these three groups will require additional investment in staff, in operating expenses, and possibly in facility improvements. Additional study of patient flow through Baker Act Receiving Facilities, especially in Sarasota and Manatee counties, may be warranted before commiting funds to new programs.

BLANK PAGE

CONTINUUM OF CARE CHART

Advocacy for supportive services are inclusive of, but not limited to:

- Medicaid/Medicare
- Meals/Nutrition
- Senior Center
- ACLF
- Guardianship
- Transportation
- Dental/Medical

I. Institutional
- A. State Mental Facilities
    - Medication
    - Day Treatment
    - Case Management
    - Screening
- B. Nursing Home Overlay
    - Medication
    - Case Management
    - Counseling Support

II. Community In-Patient Facilities
- A. Psychiatric Units
    - Counseling
    - Medication
    - Stabilization
    - Case Management
    - Supportive Systems
- B. C.S.U.
    - Crisis Stabilization
    - Medication - psychiatric
    - Referral - Detox - Screenin
    - Supportive Services
    - Care Keeper Support

III. Community Residential
- A. GR.S
    - Home
    - Case Management
    - Day Treatment
    - Psychiatric Consultation - Medicati
    - Support Services
    - Counseling for Family Significant Ot
    - Respite Care - Temporary Shelter
    - Referral

IV. Community Out-Patient
- Medication
- Psychiatric Counseling
- Supportive Services
- Case Management
- Day Treatment
- Information Referral

V. Counseling and Outreach
- Counseling for Short Term Instances
- Loss of Loved one, Crime, Ill Health
- Support Groups
- Referral and Information
- Supportive Services
- Crisis Intervention Team

I. Education and Consultation
- Prevention Seminars - Positive Health Promotion Services
- Pre-retirement
- In-service to Nursing Home Personnel on Mental Health
- Needs of Elderly
- Support Groups for Care Givers - Information
- Concerning Mental Health Issues
- Supportive Service Education

BEST COPY AVAILABLE

BLANK PAGE

How the Baker Act is implemented can vary from county to county. This can depend on the availability of receiving facilities and the sensitivity of the local authorities. Ask if anyone in the class works or has worked with the Baker Act. They may be able to add some personal experiences to the discussion.

Below are some points from the outline that can be used for discussion.

The purpose of the Baker Act. Is it fulfilling the purpose?

Access to mental health services. What, if any, impact does our growing older population have on this, especially in light of the movements for a balanced budget?

Criteria for Voluntary admission. What is the meaning of "suitable for treatment"? Who determines this?

Remind students that a court order is needed before an elderly person can be committed involuntarily to a state facility for evaluation. How is a court order obtained? Who can "Baker Act?"

Discuss the need to consider the emotional impact of an involuntary commitment not only upon the patient but also upon their family.

Discuss legal competency. Refer students to the article on guardianship in Florida.

Another good area for class discussion is the section on "Patient Rights," especially section 7, which describes how an elderly patient is to be handled. This is the ideal. How does this relate to reality in your locale? Are the police in your area sensitive to the privacy of their elderly residents? Do they attempt, whenever possible to help the client maintain their dignity? How important is this to the client's mental health?

Urge the students to review the glossary.

The instructor should emphasize to students that crimes against the elderly are widespread. The fear of being victimized is more pervasive and potentially more dangerous to the older person.

Review the most frequent crimes against the elderly. These are presented in the text. Have the class discuss some factors that might prevent an older person from reporting incidences of abuse and fraud to the authorities. Another topic for discussion among class members might be the six-point proposal by Rep. Claude Pepper. The use and practicality of the Cost of Care Index, as a pre-placement assessment tool, is another area that the class could discuss.

Hard data on the numbers of crimes committed against older people in the United States is very difficult to come by. Most metropolitan police departments do not categorize their data by the age of their victim. Professional gerontological literature tends to focus on physical abuse by formal and informal caregivers. Little has been written about the older victims of non-violent crimes. The United States Senate and House of Representatives both have committees that investigate the special problems of Older Americans. The committees publish findings of their hearings. One of the many topics that they hold hearings on is crime and the elderly. Committee reports are available through the U.S. Government Printing Office in Washington, D.C.

LEGAL ISSUES AND VICTIMIZATION

Name: ______________________________ Date: ________________

CIRCLE THE CORRECT ANSWER.

1. The Florida Mental Health Act (the Baker Act) requires that before an elderly person can be involuntarily committed to a State Mental Health facility, there must be a psychiatric evaluation and:

   a. a court order
   b. family/spouse consent
   c. HRS custody hearing

2. Prior to the Baker Act, the Florida Mental Health system consisted of:

   a. county run mental health clinics
   b. four state hospitals supported by public funds
   c. psychiatrists in public practice

3. Because of the Baker Act, most Florida counties now:

   a. have designated Baker Act receiving centers for emergency evaluation of clients
   b. charge no fees for services
   c. do not send patients to the State Mental Health hospitals

4. A person is considered incompetent by Florida law when:

   a. his or her closest relative says they are incompetent
   b. they meet specific criteria such as mental illness, minority, mental retardation, senility, etc., and are incapable of either managing property or caring for their person, or both
   c. one physician signs a statement to that effect

5. If an individual is declared incompetent they:

   a. cannot have the decision reversed
   b. will be committed to a state mental facility
   c. essentially become a "non-person"

6. The majority of con victims are:

   a. wealthy elderly
   b. males over 65
   c. females over 65

7. The elderly are particularly vulnerable to crime because of:

   a. low income and isolation
   b. wealth
   c. use of private transport

8. The major cause of abuse is:

    a. wealth
    b. vulnerability and dependence
    c. poor social skills

9. Most known physical abuse is perpetrated by:

    a. daughters
    b. sons
    c. nursing home staff

10. Prevention of abuse begins with:

    a. changing attitudes toward violence
    b. increasing penalties for abuse
    c. removal of elderly from private homes

Legal Issues and Victimization

1. a
2. b
3. a
4. b
5. c
6. c
7. a
8. b
9. a
10. a

BLANK PAGE

FROM: BAKER ACT HANDBOOK, 1985

D. INVOLUNTARY PLACEMENT OF CIVIL PATIENTS

Involuntary placement is the procedure whereby a person may be ordered to and involuntarily retained in a mental health facility or service, public or private, for a period of up to six months upon a court's determination that certain criteria are met. One of the criteria is that the patient refuses voluntary placement or retention. Involuntary placement is initiated by a facility administrator's making such a recommendation to the circuit court where the patient is located. The decision to place or retain a patient involuntarily, however, rests solely with the court. When a person is involuntarily placed, he retains his right to consent or to refuse consent to treatment unless he has been determined by the court to be incompetent to consent to treatment. (See Section on **Patient Rights**, "Right to Express and Informed Consent," in this Handbook.)

CRITERIA

A person [1] may be involuntarily placed in a mental health facility or service upon a finding by the court of clear and convincing evidence that:

1) He is mentally ill[2]; and

2) Because of his mental illness he has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or

3) He is unable to determine for himself whether placement is necessary; **and either**

4) a) He is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and without treatment he is likely to suffer from neglect or refuse to care for himself and such neglect or refusal poses a real and present threat of substantial harm to his well-being; or

b) There is substantial likelihood that in the near future he will inflict serious bodily harm on himself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; **and**

5) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his condition have been judged to be inappropriate.

INITIATION

Proceedings for the involuntary placement of a patient may be initiated only upon the recommendation of a receiving facility administrator. A patient for whom involuntary placement can be recommended may be an inpatient in the facility — if not an inpatient — may have received an examination, evaluation, or treatment by staff of the receiving facility or by a private mental health professional.

The administrator's recommendation must be entered on the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032). This certificate authorizes a facility to retain the patient pending the completion of court action on the petition for involuntary placement.

The "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032) is then filed with the court in the county where the patient is located. This certificate serves as a petition for a hearing on the patient's involuntary placement and authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

The administrator's recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the **preceding five days**, excluding weekends and court holidays, and who certify that the criteria for involuntary placement are met. In counties of less than 50,000 population, however, if the administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion, the second opinion may be provided by a licensed physician with post-graduate training and experience in the diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse.

RESPONSIBILITIES OF THE FACILITY

When involuntary placement of a patient is sought, the receiving or treatment facility must do the following:

1) File with the court a "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032) which contains the recommendation of the facility administrator and supporting opinions. This petition must be filed with the circuit court in the county where the patient is located. A copy of this petition must be retained in the patient's clinical record.

2) Provide the patient and his guardian or representatives with the following items:

a) "Notice of Petition for Involuntary Placement" (HRS-MH 3021) which states that a petition has been filed and which lists the patient's rights;

---

[1] A person who is acquitted of criminal charges because of a finding of not guilty by reason of insanity may be involuntarily hospitalized pursuant to the provisions of Chapter 916, F.S., and the applicable Florida Rules of Criminal Procedure.

[2] As defined in Section 394.455(3), F.S. (See "Mentally Ill" in **Glossary**.)

b) A copy of the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032);

c) "Petition for a Hearing on Involuntary Placement and Application for Attorney" (HRS-MH 3023) which requires only the signature of the patient, guardian, or representative; and

d) "A Waiver of Hearing for Involuntary Placement, Application for Attorney, and Application for Expert Examination" (HRS-MH 3022);

3) Explain the above written notices to the patient and assist him with the preparation of the forms which are required;

4) Provide the community mental health center or clinic which has been designated to provide evaluation and certification for State treatment facility admissions with a copy of the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032) as may be required in all cases involving potential involuntary placement in a State treatment facility. If the patient is under the age of 18, the District Case Review Committee must also be provided a copy of the petition in all cases involving potential involuntary placement in a State treatment facility. (10E-5.48(1), F.A.C.)

PATIENT RESPONSE TO NOTIFICATION OF PETITION FOR INVOLUNTARY PLACEMENT

A patient may choose to seek voluntary admission or, after advice of independent counsel, he may choose to have a court hearing.

Voluntary Admission

A patient may seek voluntary admission by signing a "Request for Voluntary Admission" (HRS-MH 3040) after receiving notice of involuntary placement proceedings. In such cases, the receiving facility must do the following:

1) Notify the court where the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032) was filed of the patient's request for voluntary admission and also inform the court that it may disregard this petition for involuntary placement by sending a "Notification to Court of Patient's Actions Regarding Hearing on Involuntary Placement" (HRS-MH 3033); and

2) Provide a copy of the above notification regarding the patient's actions and a copy of the patient's "Request for Voluntary Admission" (HRS-MH 3040) to the patient's guardian or representatives. Copies of these documents must also be provided to the designated community mental health center or clinic and to the District Case Review Committee, as applicable, in cases which involve potential admission to a State

Waiver of Hearing

A patient, unless he is under age 18 or legally incompetent, may waive his right to a hearing by signing a "Waiver of Hearing for Involuntary Placement" (HRS-MH 3022) after advice of independent counsel. If the patient has an attorney, the attorney may be present at the time the "Waiver of Hearing" form is executed.

A minor or his parent or guardian and a legally incompetent person or his guardian are not authorized to waive the right to a hearing on involuntary placement. However, in the case of a minor, a court may waive the presence of the patient from all or any portion of the hearing if the court finds that attendance at the hearing is not the best interest of the patient.

The following procedures apply in cases in which a legally competent patient may and does waive his right to a hearing on involuntary placement.

1) A facility must notify the court where the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032) was filed by sending a "Notification to Court of Patient's Actions Regarding Hearing on Involuntary Placement" (HRS-MH 3033) and a "Waiver of Hearing for Involuntary Placement" (HRS-MH 3022). The facility must also notify the patient's representatives by sending them copies of these documents. In addition, copies must be provided to the designated community mental health center or clinic, as applicable, in cases involving potential placement in a State treatment facility.

2) Even in cases in which a patient waives his right to a hearing, the community mental health center or clinic designated to provide evaluation and certification for State treatment facility admission must present a recommended placement for the court's consideration in all cases involving potential placement in a State treatment facility.

3) The court must issue an "Order for Involuntary Placement" (HRS-MH 3008). A patient must be placed in the least restrictive type of mental health facility or service based on the individual needs of each patient and within the scope of available services. However, a patient who has waived his right to a hearing may be transferred to a community or State treatment facility without awaiting court order. In cases involving transfer to a State treatment facility, approval of the Department must be obtained first and the required documentation provided to the facility.

having waived it, a court hearing must be held to determine whether a patient meets the criteria for nvoluntary placement. This hearing must be held **within five days** from the date of the service of notice, excluding weekends and court holidays, unless a continuance is granted or there is a change of location (venue).

The community mental health center or clinic designated to provide evaluation and certification for State treatment facility admission and the District Case Review Committee, as applicable, must present their recommendations regarding placement of the patient for the court's consideration prior to court action on the petition in all cases of potential placement in a State treatment facility.

If a patient waived his right to a hearing and was nvoluntarily placed, at any time within six months of he date of the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032), the patient or his guardian or a representative may file a "Petition for Hearing on Involuntary Placement and Application or Attorney" (HRS-MH 3023). The "Petition for a Hearing" must be filed with the court in the county in which the patient is involuntarily placed and the hearing must be held in the same county. One of the patient's physicians at the facility where the patient is nvoluntarily placed must appear as a witness at the hearing.

Responsibilities of the Court

When a hearing on involuntary placement is to be held, the court must ensure that the following takes place:

1) The court must serve a "Notice of Hearing on Petition for Involuntary Placement" (HRS-MH 3007) on the patient, his guardian or representatives, the facility administrator, and the State Attorney of the udicial circuit of the county in which the patient is ocated. The notice shall specify the date, time, and place of hearing; the basis for detention; and the name of each examining expert and of other persons who are expected to testify in support of involuntary placement.

2) The court must hold the hearing **within five** court working days from the date of service of notice unless a continuance is granted or there is a change of ocation (venue). Venue may be ordered changed within the discretion of the court.

3) The court must ensure that the hearing is as convenient to the patient as may be consistent with orderly procedure and is conducted in a physical setting not likely to be injurious to the patient's condition.

4) The court must inform the patient and his guardian or representatives of the right to counsel and the right to an independent expert examination hrough the "Notice of Hearing on Petition for Involuntary Placement" (HRS-MH 3007). If the patient cannot afford an attorney, the court is required to appoint one. The patient's counsel must have access to facility records and to facility personnel in representing the patient. In addition, the court must provide for an independent expert examination when one is requested and the patient cannot afford the cost of such examination.

5) The court must ensure that one of the professionals who executed the involuntary placement certificate serve as a witness at the hearing.

6) In a proceeding involving a person under age 18, the hearing cannot be waived. However, if at the hearing the court finds that the patient's attendance at the hearing is not in the best interests of the patient, it may waive the presence of the patient from all or any portion of the hearing.

7) If the court concludes that the patient meets the criteria for involuntary placement, then the court must issue an "Order for Involuntary Placement" (HRS-MH 3008). This order must adequately document the nature and extent of the patient's mental illness. The patient must be involuntarily placed in the least restrictive type of mental health treatment facility or service based on the individual needs of each patient and within the scope of available services.

8) At the hearing on involuntary placement, the court must consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment [1], it must appoint a guardian advocate to act on the patient's behalf relating to the provision of express and informed consent to treatment for mental illness.

9) The court may adjudicate a person legally incompetent pursuant to the provisions of Chapter 744 [2] at the hearing on involuntary placement.

10) The court must provide a court order, the "Order for Involuntary Placement" (HRS-MH 3008), a psychiatric evaluation, and other adequate documentation of each patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary placement. The administrator of a treatment facility may refuse admission to any patient directed to the facility on an involuntary basis who is not accompanied at the same time by adequate orders and documentation.

If—while awaiting transfer to a State treatment facility following an involuntary placement order—a patient improves to the degree that such transfer appears to be unnecessary, the public or private receiving facility must notify the court of this situation and request the court's consideration of a less restrictive treatment alternative. This notification must be preceded by consultation with the community mental health center or clinic which provided the screening and certification.

DISPOSITION FOLLOWING A COURT ORDER FOR INVOLUNTARY PLACEMENT

Any required patient transfer to a State treatment facility must be arranged in accordance with the provisions of this Act regarding transfer. (See the Section on **Facility Transfer** in this Handbook.)

TIME LIMIT FOR INVOLUNTARY PLACEMENT

A facility is authorized to retain a patient for a period not to exceed six months from the date of the "Order for Involuntary Placement" (HRS-MH 3008). If continued involuntary placement is necessary at the end of that period, the administrator must file 20 days prior to the expiration of current placement with the Department of Administration, Division of Administrative Hearings, for an order authorizing continued involuntary placement. (394.467(4)(g), F.S.; 10E-5.48 10E-5.49, F.A.C.)

INVOLUNTARY PLACEMENT

Check List for Receiving Facilities and Other Community Programs

To initiate involuntary placement proceedings, the facility must:

- ____ Complete the "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032), signed
    - ____ Facility administrator; and
    - ____ Psychiatrist who has examined the patient within preceding 5 days; and
    - ____ Psychiatrist, clinical psychologist, licensed physician,[1] or psychiatric nurse[1] who has examined patien within preceding 5 days
- ____ File the petition with the court on the court's first working day after the petition has been signed
- ____ Provide the patient and his guardian or representatives with copies of:
    - ____ "Notice of Petition for Involuntary Placement" (HRS-MH 3021)
    - ____ "Petition for Involuntary Placement and Placement Certificate" (HRS-MH 3032)
    - ____ "Petition for a Hearing on Involuntary Placement and Application for Attorney" (HRS-MH 3023
    - ____ "A Waiver of Hearing for Involuntary Placement, Application for Attorney, and Application for Exper Examination" (HRS-MH 3022)
- ____ Explain the above forms to the patient and assist him with their preparation, if required

In the case of **potential placement in a State hospital**, see "Check List for Screening and Certification for Stat Treatment Facility Admission" in this Handbook.

If the **patient seeks voluntary admission** (after notification of involuntary placement proceedings):

- ____ **Patient must** sign "Request for Voluntary Admission" (HRS-MH 3040)
- ____ **Facility must**:
    - ____ Provide court with "Notification to Court of Patient's Actions Regarding Hearing on Involuntary Placement" (HRS-MH 3033)
    - ____ Provide to patient's guardian or representatives copies of:
        - ____ "Notification to Court of Patient's Actions Regarding Hearing on Involuntary Placement" (HRS-MH 3033)
        - ____ "Request for Voluntary Admission" (HRS-MH 3040)

---

[1] Only in counties of less than 50,000 population and if no psychiatrist or clinical psychologist is available to provide second opinion

—— In the case of **potential admission to State hospital**, provide copies of above to:

  —— Assigned CMHC or clinic (if facility is not a CMHC or clinic)

  —— District Case Review Committee (if patient is a minor)

f the patient[1] seeks to waive his right to a hearing after advice of independent counsel:

—— The patient must sign a "Waiver of Hearing on Involuntary Placement" (HRS-MH 3022)

—— The facility must:

  —— Provide to the court and to the patient's representatives copies of:

    —— "Notification to Court of Patient's Actions Regarding Hearing on Involuntary Placement" (HRS-MH 3033)

    —— "Waiver of Hearing on Involuntary Placement" (HRS-MH 3022)

  —— In the case of **potential placement in a State hospital**, provide copies of the above to:

    —— CMHC or clinic (if facility is not a CMHC or clinic) assigned to perform screening and certification for State hospital placement

the case of potential placement in a State hospital,[2] the CMHC or clinic assigned to perform the screening and rtification and the District Case Review Committee (when the patient is a minor) must:

—— Present to court a recommended placement for the court's consideration before court action on the petition for involuntary placement

BEST COPY AVAILABLE

E. CONTINUED INVOLUNTARY PLACEMENT

A patient may continue to be involuntarily placed in any designated public or private receiving or treatment facility after a hearing officer adjudicates that the patient continues to meet the criteria for involuntary placement and issues an "Order for Continued Involuntary Placement" (HRS-MH 3031).

INITIATION

A receiving or treatment facility must determine if an involuntary patient continues to meet the criteria for involuntary placement in the following instances: prior to the expiration of the patient's authorized placement period; prior to the date an involuntarily placed minor will reach the age of majority; or, in the case of a person admitted while serving a criminal sentence, prior to the expiration of his sentence or his release.

If the patient is found to meet the criteria for involuntary placement, the facility is required to initiate proceedings for continued involuntary placement through the following actions:

1) A "Request for Order Authorizing Continued Involuntary Placement" (HRS-MH 3035) must be sent to the hearing officer **not more than thirty days nor less than twenty days** prior to the expiration date of a patient's authorized period of placement or, in the case of a minor, the date when the patient will reach 18 years of age, whichever is earlier.

2) This request must contain the signed statement of the patient's physician or clinical psychologist justifying the request and must be accompanied by the following additional documentation:

a) Support for the facts in the statement by the physician or clinical psychologist;

b) A brief summary of the patient's treatment during the time he was placed; and

c) An individualized treatment plan.

3) Upon initiation of proceedings for continued involuntary placement, the facility must send the following notifications:

a) The patient must receive a "Notification to Patient of Request for Continued Involuntary Placement" (HRS-MH 3024A), an "Application for Attorney" (HRS-MH 3005), and a copy of the "Request for Order Authorizing Continued Involuntary Placement" (HRS-MH 3035).

b) The patient's guardian or representatives must be sent a "Notice to Guardian or Representatives of Request for Continued Involuntary Placement" (HRS-MH 3024B), an "Application for Attorney" (HRS-MH 3005), and a copy of the "Request for Order Authorizing Continued Involuntary Placement"

Both notification forms (HRS-MH 3024A and HRS-MH 3024B) state that the patient is entitled to a hearing under the law; that the patient is entitled to be represented by an attorney at the hearing and, if he cannot afford an attorney, that one will be appointed; and that, if it is shown at the hearing that the patient does not meet the criteria for involuntary placement, he is entitled to be released. In addition, the notification to the patient (HRS-MH 3024A) incorporates a waiver-of-hearing form.

WAIVER OF HEARING

A patient, unless he is under age 18 or legally incompetent, may waive his right to a hearing after advice of independent counsel, for continued involuntary placement by signing a "Waiver of Hearing" found on form HRS—MH 3024A. A parent or guardian of a patient who is under age 18 or legally incompetent may not waive a hearing for continued involuntary placement.

If a hearing is waived and no hearing is noticed, the hearing officer must sign the "Order for Continued Involuntary Placement" (HRS-MH 3031).

Even when a patient waives his right to a hearing, a hearing officer has the authority to notice a hearing on his own motion. Further, at any time continued placement is requested, the facility administrator may request a hearing and the hearing officer is required to hold a hearing **within thirty days** of the request.

RESPONSIBILITIES OF HEARING OFFICER

1) The hearing officer is required to hold a hearing on a patient's continued involuntary placement **within thirty days** after receiving a request from a facility administrator, unless, after the advise of independent counsel, the patient has waived his right to a hearing. The hearing must be held in the following situations:

a) When the patient does not sign a waiver of hearing within fifteen days after receiving a "Notification to Patient of Request for Continued Involuntary Placement" (HRS-MH 3024A) and a "Request for Order Authorizing Continued Involuntary Placement" (HRS-MH 3035); **or**

b) When the patient or his guardian or representative does not sign the petition for a hearing on either the "Notice to Patient of Request for Continued Involuntary Placement" (HRS-MH 3024A) or the "Notice to Guardian or Representatives of Request for Continued Involuntary Placement" (HRS-MH 3024B); **or**

c) When the patient or his guardian or representative returns a signed petition for a hearing on either form HRS-MH 3024A or form HRS-MH 3024B; **or**

2) The hearing officer must notice a hearing for continued involuntary placement by sending a "Notice of Hearing for Continued Involuntary Placement" (HRS-MH 3029) to the following:

a) The patient;

b) His guardian or representatives;

c) The facility administrator; and

d) The patient's attorney, as applicable.

3) The hearing officer must inform the patient and his guardian or representatives of the right to counsel. If the patient cannot afford counsel in a hearing before a hearing officer, the public defender in the county where the hearing is to be held shall act as attorney for the patient.

4) The hearing officer must conduct the hearing in accordance with Chapter 120, Florida Statutes.

5) In a proceeding involving a person under age 18, the hearing cannot be waived. However, if at the hearing the hearing officer finds that the patient's attendance at the hearing is not in the best interests of the patient, he may waive the presence of the patient from all or any portion of the hearing.

6) The hearing officer is required to sign the "Order for Continued Involuntary Placement" (HRS-MH 3031) if at the hearing it is shown that the patient continues to meet the criteria for involuntary placement or if the patient has waived his right to a hearing by express and informed consent after advice of independent counsel.

7) At any hearing for continued involuntary placement, the hearing officer is required to consider testimony and evidence regarding the patient's competence in the case of a patient who has been previously adjudicated incompetent to consent to treatment. If the hearing officer finds evidence that the patient is competent to consent to treatment, then he may issue to the court a recommended order that the patient's competence be restored and that any guardian advocate previously appointed be discharged. The court to receive the recommended order is the circuit court in the county in which the patient was adjudicated incompetent to consent to treatment.

TIME LIMIT FOR CONTINUED INVOLUNTARY PLACEMENT

After a hearing officer signs the "Order for Continued Involuntary Placement" (HRS-MH 3031), a treatment facility is authorized to retain the patient for a period not to exceed six months. The procedure described in this section must be repeated prior to the expiration of each additional six-month period the patient is retained. There are two exceptions. In the case of involuntarily placed minors, a determination must be made prior to the date when the patient will reach 18 years of age, if this is earlier than the date the involuntary placement order will expire. In the case of individuals involuntarily placed while serving a criminal sentence, the determination regarding the need for continued placement must be made prior to the date the patient's sentence will expire if this is earlier than the expiration of the involuntary placement period. (394.467(4), F.S.; 10E-5.49 F.A.C.)

NOTES

BEST COPY AVAILABLE

B. LEGALLY INCOMPETENT PERSONS

INTRODUCTION

According to Florida law, a person is considered to be incompetent when he meets the following criteria: ". . . a person who, because of minority, mental illness, mental retardation, senility, excessive use of drugs or alcohol, or other physical or mental incapacity, is incapable of either managing his property or caring for himself, or both." [1]

LEGAL COMPETENCY vs. COMPETENCY TO CONSENT TO TREATMENT

A determination of legal incompetency of an individual as described above is a **separate** judicial decision from that of determining if a patient requires involuntary placement or determining if a patient is incompetent to consent to treatment

If a person is found to meet the definition of legally incompetent in accordance with Chapter 744, then a legal guardian is appointed by a court to maintain custody and control of the person and/or of the property of a person adjudicated incompetent.

If the court finds that the patient is **incompetent to consent to treatment**, then it must appoint a **guardian advocate** who shall act on the patient's behalf relating solely to the provision of express and informed consent to mental health treatment. (394.467(3), F.S.)

Upon discharge from active treatment, a patient's competency to consent to treatment is restored. This does **not** apply to legal competency.

DETERMINATION OF LEGAL COMPETENCY

A petition to determine competency may be filed with the court only when it is believed that the patient meets the definition of incompetency pursuant to Chapter 744, Florida Statutes, [1]and that he requires a guardian of person or property or both.

RESTORATION OF LEGAL COMPETENCY

All facilities must evaluate legally incompetent patients, at the time of admission and at six-month intervals thereafter, to determine if the patient continues to meet the statutory definition for incompetency found in Section 744.102(5), F.S.

A certificate of competency must be issued to any legally incompetent person who is an outpatient or inpatient of any designated receiving or treatment facility upon a determination that the person no longer meets the statutory definition of incompetency. Upon such a determination, the facility must respond as follows:

1) A designated private or public receiving facility must issue a Certificate of Competency issued at a Designated Receiving Facility signed by two licensed physicians and a responsible staff member.

2) A designated private or public treatment facility must issue a "Certificate of Competency" (HRS-MH 3034) signed by three licensed physicians of the facility.

3) The administrator of the designated public or private receiving or treatment facility must send the original certificate of competency to the Clerk of the Circuit Court where the person was originally adjudicated incompetent, retain one copy in the clinical record, and provide a copy to the patient. The certificate is admissible as evidence in any hearing for the restoration of competency of such person and is prima facie evidence that such person is competent (Ch. 744.464(1)(a)).

4) The mental health facility should notify the appropriate State Attorney and the patient's guardian(s), if any, upon filing a certificate of competency. The "Notice to State Attorney and Guardian of Petition to Restore Competency" (HRS-MH 3019) may be used for this purpose. The notifications must be accompanied by a copy of the "Certificate of Competency" (HRS-MH 3034 or HRS-MH 3054) and a copy of the proposed "Order for Restoration of Competency" (HRS-MH 3020).

5) If the State Attorney signs a waiver of objection or fails to file an objection within the required 20-day period and an order restoring the patient's competency is subsequently not received, then the facility must contact the clerk of the circuit court requesting that a copy of the order be sent to the patient, his guardian, and to the facility.

6) If an objection to the restoration is made, then the mental health facility must inform the patient of his right to have a Petition for Restoration of Competency filed on his behalf by a relative, spouse, or friend. If there are no relatives available, the facility must make extensive efforts to locate a friend to act on behalf of the patient. This Petition for Restoration of Competency may be filed in either the county of original adjudication of incompetency or the county where the patient is currently living. A copy of the petition must be sent to the State Attorney and to the guardian(s). In the case of indigency, the court may appoint an attorney to represent the incompetent patient. If no one is available to file on behalf of the patient, the facility administrator, in consultation with the facility's attorney, must determine the appropriate party to file on a case-by-case basis. (744.331, 744.464, F.S.; 10E-5.59, F.A.C.)

RESTORATION OF LEGAL COMPETENCY

Check List for Mental Health Facilities

In the case of a legally incompetent patient, a mental health facility must:

____ Evaluate the legally incompetent patient at the time of admission and at six-month intervals to determine if t patient continues to meet the statutory definition of incompetency (Section 744.102, F.S.)[1]

Upon a determination that the person no longer meets the statutory definition of incompetency:

- ____ A public or private **receiving facility** must:
  - ____ Issue a "Certificate of Competency" (HRS-MH 3034), signed by three licensed physicians and a s member.
- ____ A public or private **treatment facility** must:
  - ____ Issue a "Certificate of Competency" (HRS-MH 3034), signed by three licensed physicians at the fac
- ____ All public or private receiving or treatment facilities must:
  - ____ Send the original certificate of competency to the clerk of the circuit court where the person was origin adjudicated incompetent, retain one copy in the clinical record, and provide a copy to the patie
  - ____ Notify the appropriate State Attorney and the patient's guardian (if any) upon filing a certificate competency (The "Notice to State Attorney and Guardian of Petition to Restore Competency"--HRS- 3019--may be used for this purpose.)
    - ____ The notifications must be accompanied by copies of:
      - ____ "Certificate of Competency" (HRS-MH 3034), and
      - ____ "Order for Restoration of Competency" (HRS-MH 3020)

If the State Attorney signs a waiver of objection or fails to file an objection within the required twenty-day period an order restoring the patient's competency is subsequently not received, then the facility must:

____ Contact the clerk of the circuit court requesting that a copy of the order be sent to the patient, his guardian, the facility

If an objection to the restoration is made, the mental health facility must:

____ Inform the patient of his right to have a petition for restoration of competency filed on his behalf by a rela spouse, or friend

____ Make extensive efforts to locate a friend to act on behalf of the patient if no relatives are available

____ Ensure that the facility administrator, in consultation with the facility's attorney, determine the appropriate p to file on behalf of the patient if no relatives or friends can be located to file on behalf of the patient

If the Petition for Restoration of Competency is filed on behalf of the patient:

____ The petition may be filed in either the county of original adjudication of incompetency or in the county where patient is currently living

____ A copy of the petition must be sent to the State Attorney and to the guardian(s)

In the case of indigency, the court:

____ May appoint an attorney to represent the incompetent patient

---

[1] "... a person who, because of minority, mental illness, mental retardation, senility, excessive use of drugs or alc or other physical or mental incapacity, is incapable of either managing his property or caring for himself, or bo

[2] The certificate is admissible as evidence in any hearing for the restoration to competency of such person and is p facie evidence that such person is competent.

Copyright 1985 by
The Gerontological Society of America

Incompetency and guardianship proceedings in Leon County, Florida were examined observing court hearings and evaluating probate court records for 1977–1982. incompetency petitions were affirmed by the court, often without evidence describing alleg disabilities. Evidence from Leon County indicates a clear mandate for administrative chang providing 1) more comprehensive assessment of client disabilities and 2) more rigoro financial accounting and management of guardianships. The evidence also suppo recommendations in the available literature for statutory change, judicial remedy, a education and traini

Key Words: Guardianship, Incompetence, Public guardian, La

Guardianship of the Elderly in Tallahassee, Florida[1]

Roger Peters, MS,[2] Winsor C. Schmidt, Jr., LLM
and Kent S. Miller, Ph

Changes in mental disability law over the past decade have significantly affected methods of processing forensic and civilly committed patients but have largely bypassed a smaller and less vocal group of mentally disabled individuals who are subject to guardianship procedures. One study of six states (Delaware, Minnesota, North Carolina, Ohio, Washington, and Wisconsin) found only 17,000 guardianship petitions filed in one year for a total population of 29,000,000 people (Axilbund, 1979). A similar filing rate of 4,729 new guardianships for a population of 8,432,927 was reported for Florida in 1977 (Schmidt, 1981).

Guardianship is a legal phenomenon consisting of the authority of a guardian and the relation between guardian and ward (Schmidt, 1981). A guardian manages the person and/or property of another, the "ward," who is adjudicated incompetent and considered incapable of self-administration. Most states employ a bifurcated process in establishing guardianships. The initial stage involves an incompetency hearing to examine and discuss threshold criteria of "inability to do business, manage property, or conduct personal affairs" by reason of conditions "affecting mental capacity, such as mental illness, alcoholism, addiction, or old age" (Regan & Springer, 1977, p. 36). Incompetency hearings serve as a forum for the court to consider the extent of physical and mental incapacities of the ward and to assess the available human resources in the community to ove see these incapacities.

The second stage of the process involves a guar ianship hearing to assign decision-maker respons bilities, to either a private or public guardian. Th guardian is usually a family member or friend, but i the absence of willing and responsible family mem bers or friends to serve as private guardians or resources to acquire professional guardian service from private attorneys or banks, a public official ca be appointed as public guardian (Schmidt et al 1981). Public guardians are affiliated with the court i some states and with social service agencies i others. In several states, such as Arizona, publi guardians are independent of other judicial or se vice agencies (Regan & Springer, 1977).

Procedural and Substantive Issues

Guardianship leads to a deprivation of civil right and has been referred to as a "highly restrictiv method of providing supervision and assistance" t the mentally disabled by the President's Commissio on Mental Health (Report of the Task Panel on Lega and Ethical Issues, 1978, p. 43). Because of the similarities and necessary overlap between guardianshi and involuntary commitment proceedings, the Commission recommended that research in the area guardianship be given a "high priority." Concern i growing among those involved in law and social gerontology about the expanded use of guardianshi (Mitchell, 1979; Regan, 1981, 1982; Sherman, 1980) Proponents of guardianship reform contend that se eral procedural and substantive issues demand attention and militate against further use of guardianship statutes (Regan, 1981, 1982; Schmidt, 1981).

Incompetency and guardianship hearings do no

---

[1] The authors gratefully acknowledge the help of Jim Cameron, M.A., in data collection and the cooperation and assistance of the judges and personnel of the District 2B Circuit Court, Probate Division, Tallahassee, FL.

[2] Doctoral candidate in Clinical Psychology, Department of Psychology, Florida State University, Tallahassee, FL 32306.

[3] Associate Professor, Department of Public Administration, Florida State University, Tallahassee, FL 32306.

[4] Professor, Department of Psychology, Florida State University, Tallahassee, FL 32306.

always reflect the need to preserve maximum liberties of the potential ward. Notifications of incompetency and guardianship hearings often do not describe their legal implications (Sales, 1979), and legal counsel for the alleged incompetent is frequently absent in guardianship proceedings (Alexander & Lewin, 1972; Horstman, 1975). Many states do not provide counsel to indigents compelled to appear at incompetency or guardianship hearings or instead provide guardians ad litem, whose responsibilities are statutorily vague (Sherman, 1980; Solender, 1976). It is unclear, for example, what the guardian ad litem's role might be in initiating appeals of incompetency or guardianship hearings, if this is desired by the ward, or refusing unwanted treatment on behalf of the ward.

Once established, guardianships are rarely monitored by the court. Only 10 states sanction regular court reviews of legal guardianships (Sales, 1979). Even when required by law, reviews often provide little more than a financial accounting of the ward's estate and offer little evidence about changes in the ward's intellectual or physical status that might be of interest to the court in reevaluating the need for guardianship. Further, no statutory incentives are provided for the guardian to initiate restoration of competency on behalf of the ward.

Guardianship represents both a transfer of decision-making power from one individual to another and a significant sacrifice to the party yielding this power. Yet, in many cases, a ward may retain some degree of intellectual competence, especially in the care of immediate property or decisions about personal needs. Most states, however, do not recognize a state of partial incompetence (Axilbund, 1979). As a result, guardianship proceedings divest the ward of all major decision-making power, which can facilitate physical and psychological deterioration (Schmidt, 1981). The intrusiveness and rigidity of plenary guardianship provisions, employed by about two-thirds of the states, have been heavily criticized. It has been demonstrated that the loss of decision-making power actually leads to individual dysfunction in both social and domestic settings (Horstman, 1975). Thus, plenary guardianship can become a self-fulfilling prophecy of sorts — the finding and judicial ratification of incompetence discourage individual creativity and intellectual pursuits, leading to a progressive dependence on appointed guardians, loss of self-esteem, and loss of motivation to maintain self-help and management skills. Further, the serious consequences of guardianship actually deter caretakers from seeking protective services for individuals who require only moderate supervision and who are at least partially competent to care for themselves (Sherman, 1980). In order to remedy such shortcomings, some states have begun to adopt limited guardianship statutes (Axilbund, 1979).

Guardianship Research

Although studies have identified the need for substantive and procedural reform of guardianship statutes, few have systematically examined the impact of statutory deficiencies on the guardianship process. Alexander and Lewin (1972) conducted an archival search of incompetency and guardianship records in New York in order to investigate procedures for determining incompetency and administration of guardianships established by the court. They discovered that findings of incompetency were based on inadequate information, often in the form of conclusory psychiatric or medical conjecture. None of the incompetency records attempted to specify the functional nature of the person's incapacity. The incompetency hearing was found to be a "rubber stamp approval" of the incompetency petition, previously agreed to by both the petitioner and the guardian. Rarely did the guardian ad litem or counsel raise any objections to the incompetency finding.

Alexander and Lewin also found that guardianships were poorly monitored. In 82% of the cases sampled, financial records or annual accountings were incomplete. Although authorized by law, the court failed to impose sanctions on delinquent guardians. Finally, the study concluded that guardians were not encouraged to develop the management skills of their wards. As a result, except for those supervised within veteran's hospitals, few wards were restored to competency.

Field research by Schmidt et al. (1981) examined a sample of incompetency and guardianship hearings in six states, substantiating claims made by Alexander and Lewin (1972) that these hearings were procedurally inadequate. Applications for guardianship were rarely denied, and hearings were brief, nonadversarial, and subject to several due process deficiencies. Restorations to competency were rare, as were voluntary guardianships and meaningful reviews of guardianships by the court. Schmidt et al. found that guardianship proceedings were also substantively deficient. Among the states surveyed, the authors found that partial or limited guardianships were rarely established, although this option was available to the courts.

Thus, recent studies of guardianship law and proceedings help to elaborate potential violations of due process rights and abuses of the supervisory privileges in such caretaking relationships. Few studies, however, attempt to analyze incompetency and guardianship proceedings at the microcosmic, or client, level. Review of research in the area of guardianship suggests that several areas in particular warrant further investigation.

(1) Identification of client population served. Does guardianship serve primarily an elderly population? What is the financial status of wards adjudicated incompetent and of appointed guardians? Are guardianships established only for wealthy clients? To what degree are wards mentally and physically incapacitated? How often do relatives assume responsibility for guardianships?

(2) Legal bases for incompetency determinations. Is psychiatric testimony contested in determining incompetency? Does an independent examination by medical personnel assist the court in determining the need for

guardianship and the type of guardianship to be established? Is the original petition to determine incompetency screened by the court for statutory deficiencies? On what basis does the court make its final decision regarding competency.?

(3) Substantive issues. Does the court consider use of limited guardianships when a ward is only partially incapacitated? How often are reviews of guardianships submitted or solicited by the court? Are penalties assessed against guardians who are negligent in submitting annual accountings to the court? Are affirmative treatment goals established?

(4) Procedural issues. Is the potential ward and his or her family notified in advance of an impending hearing to determine incompetency or to select a guardian? What is the length of time between the petition to determine competency, the incompetency hearing, and the guardianship hearing? Does the court allow more time to select guardians in cases involving large estates? Do a variety of doctors participate in examining committees? Are the bonds required of newly appointed guardians reasonable? Are bonds assessed in a uniform and consistent manner? Is counsel provided for indigent alleged incompetents?

The present study attempts to address these issues by analyzing both the content and process of incompetency and guardianship hearings. The content of eight hearings was sampled both through direct observation by the authors of all the hearings for several months and by an archival search of court records. The study was undertaken by examining all records of incompetency and guardianship hearings referred to the District 2B Circuit Court, Probate Division, in Tallahassee, Florida, from January 1977 to May 1982. Records contained all correspondence initiated or processed by the court, including petitions, notification, orders, and reports, as well as all documents adjudicating incompetency and appointing guardians. The District 2B Probate Court is responsible for reviewing all petitions for incompetency and guardianship in Leon County, Florida.

Guardianship Law in Florida

The Florida guardianship statute requires that a ward be adjudicated incompetent before a guardian may be appointed. A finding of incompetency must be predicated on "minority, mental illness, mental retardation, senility, excessive use of drugs or alcohol, or other physical or mental incapacity" (Florida Guardianship Law, Fla. Stat. § 744.102(5), 1983). The incapacity should be such that the person "is incapable of caring for himself or managing his property or is likely to dissipate or lose his property or inflict harm on himself or others" (Florida Guardianship Law, Fla. Stat. § 744.331(1), 1983). The petition to determine incompetency may be filed by either the immediate family of the ward, any three citizens of the state, or the medical director of a state correctional institution on behalf of an inmate. After a petition has been filed, the court is obligated to establish a hearing date and to send written notice of the hearing to the alleged incompetent and one or more members of his or her family. No provision is made concerning maximum elapsed time allowed between written notice and incompetency hearings.

Incompetency hearings in Florida are to be conducted in an "informal" manner. If the alleged incompetent cannot afford legal counsel, an attorney is appointed for him or her. No provision is made for juries to hear either incompetency or guardianship cases. An examining committee, consisting of two physicians "who shall not be associated with each other in the practice of medicine" and one other Florida citizen, is used to determine the physical and mental condition of the individual (Florida Guardianship Law, Fla. Stat. § 744.331 (5)(a), 1983). (Thirty-two other states have some statutory provision for an examination, usually by at least one physician (Sales, 1979).) A committee finding of competency invalidates the original petition; an incompetency finding must be subsequently verified by the probate court in a hearing.

Upon a finding of incompetency, an individual must be assigned a guardian of the person. In Florida, individual or nonprofit corporations may be appointed as guardians and are responsible for providing humane care and treatment for the ward. Each ward must be provided an annual physical examination by a licensed physician. In addition, annual reports must be submitted to the court detailing the guardian's activity, the personal status of the ward, and the financial status of the ward's estate. The court is allowed a wide degree of discretion in appointing guardians, choosing from among residents of Florida, non-residents, trust companies/banks, or nonprofit corporations.

One aspect of Florida law providing some flexibility to the court is the provision for "limited" guardianship (Florida Guardianship Law, Fla. Stat. § 744.303, 1983). By this mechanism, a limited guardian of the property may be appointed "[w]hen it appears to the satisfaction of the court that an incompetent is over the age of 18 years and wholly or substantially self-supporting by means of compensation from employment." A limited guardian of property is, for example, empowered to handle financial transactions, including property other than wages or other monetary compensation.

Demographic Findings

Forty-two pairs of incompetency/guardianship cases from 1977–1982 were evaluated. Three cases involving guardianships for minors were not included in the study. Table 1 describes several demographic, diagnostic, and financial characteristics of individuals referred for incompetency/guardianship hearings. The average age of individuals referred for incompetency and guardianship hearings was 73 years. Almost 75% were 70 years of age or older, and only 12% were younger than 60. Fully two-thirds of the wards were females. The preponderance of wards lived in private homes, but 31% resided in rest homes or hospitals at the time of the petition. Relatives were available and willing to serve as guardians in 70% of the cases surveyed.

Table 1. Characteristics of Incompetency/Guardianship Referrals in Leon County, Florida

Characteristic	n	%
Age		
90 and above	2	5
80–89	15	36
70–79	14	33
60–69	6	14
Less than 60	5	12
(Range: 18–96; $\bar{m}$ 73)		
Gender		
Female	29	69
Male	13	31
Residence at time of hearing		
Private home	28	67
Nursing home or home for aged	9	21
Hospital	4	10
Unknown	1	2
Size of estate		
Greater than $100,000	9	21
$50–$100,000	11	26
$25–$50,000	5	12
Less than $25,000	13	31
Unknown	4	10

Characteristic Diagnosis	n (At time of petition)	% (At time of petition)	n (Of examining committee)	% (Of examining committee)
Age related[a]	16	38	30	71
Reference to simple "medical" or "physical" incapacity	16	38	0	0
Medical disorders[b]	6	14	10	24
Retardation	0	0	2	5
Unknown	4	10	0	0

[a] Organic brain syndrome, senility, Alzheimer's Disease.

[b] Stroke, brain damage, epilepsy.

Incompetency Hearings

The court relied on a large group of physicians from the community to serve on examining committees. In 42 incompetency hearings, 45 different physicians were employed by the court, including eight psychiatrists. Psychiatrists were appointed in 60% of cases in which doctors were asked to serve on more than one examining committee. No physician appeared on more than seven examining committees (mean = 1.7 appearances per physician and 3.8 appearances per psychiatrist on examining committees in our sample).

This experience in Leon County should be contrasted with the results of a grand jury investigation in Dade County (Miami), Florida (Dade County Grand Jury, 1982). The grand jury's study of 200 randomly selected files chosen from guardianship cases opened between 1979 and 1981 revealed that the same two physicians were appointed to the examining committee in every case, generating fees of $75 apiece for each examination at a rate of 40 to 50 examinations per month over several years. The grand jury cited a need to broaden the composition of the examining committee and suggested that the appointment of physicians should not necessarily be limited to psychiatrists.

All petitions requesting an incompetency hearing were heard by the court. In 38% of cases, no specific functional or descriptive analysis was provided explaining the rationale for such a petition. The alleged incompetent was simply described in conclusory fashion as having "mental or physical incapacities" — terminology from the Florida statute. Thus, in a large portion of the cases, the court did not require behavioral evidence of incompetency in the petition but deferred to the summary statements of the examining committee in order to establish the threshold question of mental/physical disabilities.

In the vast majority of cases the court issued notification of an impending hearing to the alleged incompetent and family members within one day of the petition. In 29% of cases surveyed, the court scheduled incompetency hearings within a week of petitions. In these cases it appears that alleged incompetents, family members, legal counsel, or other interested parties were allowed minimal opportunity to marshal arguments challenging the basis for petitions. There was no indication that the petitions concerned emergency situations such as consent to surgery.

In only 57% of cases did probate court records contain reference to attorneys appointed on behalf of alleged incompetents. In half of the remaining cases (21% overall) petitioner's attorneys were named in court records without reference to attorneys for the alleged incompetent. It is unclear whether these omissions represent clerical oversight or failure of the court to appoint legal counsel for alleged incompetents. Florida Statutes Section 744.331 (4) provides that the opportunity to be represented by counsel must be accorded and mandates the appointment of an attorney if the alleged incompetent cannot afford one. The Florida Supreme Court has ruled that "a trial judge must specifically find whether or not the alleged incompetent is represented by counsel in any hearing where incompetency is to be determined, and whether or not counsel should be afforded. Failure to make such a finding constitutes reversible error" (*In re* Guardianship of Paunack, 1978).

Of 42 hearings, all resulted in a finding of incompetency. Findings appeared to be heavily influenced by psychiatric diagnoses. Judges did not depart significantly from these diagnoses or from the psychiatric determinations of incompetency rendered by the examining committee. Judges concurred with all 42 of the incompetency decisions and did not appear to solicit additional behavioral or psychiatric evidence regarding functional incompetence of the potential ward. In most cases, the diagnosis provided by the examining committee was reiterated verbatim by the court in adjudicating incompetency.

The composition of diagnoses provided by the examining committee differed significantly from those provided by the petitioner. Instead of relying on statutory criteria for a determination of incompetency, examining committees defined incompetency using medical and psychiatric terminology. About 71% of these diagnoses were based on findings of age-related disorders (senility, organic brain syndrome, Alzheimer's disease), compared to only 38% of age-related disorders specified in incompetency petitions. Examining committees also tended to designate other medical disorders (stroke, epilepsy, brain damage) more frequently in determining incompetency. Reliance on more formal diagnostic categories may be explained at least in part by the medical/psychiatric background of members of the court-appointed examining committee. Fully 98% of alleged incompetents were characterized by chronic (vs. acute) disorders, according to the examining committee. Eighteen percent were allegedly in need of physical restraints as a result of their incapacitating disorders.

Despite the use of more technical and seemingly more precise language, diagnoses rendered by the examining committee did not significantly improve upon those set forth in incompetency petitions. In only 15% of incompetency cases did the diagnosis refer to the etiology, onset, or history of the incapacitating disorder (e.g., brain damage secondary to head injury). Perhaps more importantly, examining committee diagnoses failed to describe the nature or extent of physical incapacity in 93% of cases. Mental incapacities were not behaviorally described in 88% of cases. Thus, in about 90% of cases reviewed, examining committee reports did not provide specific behavioral information for the court that is statutorily required (Florida Guardianship Law, Fla. Stat. § 744.331(1), 1983) pursuant to an adjudication of incompetency.

Guardianship Proceedings

As indicated by Alexander and Lewin (1972), the size of estates identified for guardianship is often substantial. Of the guardianship files examined, 9 (21%) involved estates valued greater than $100,000, and 20 (47%) involved estates above $50,000. The mean size of estates was about $75,000. Florida law allows the judiciary discretion to require appointed guardians to place a bond deposit with the court before assuming financial responsibility for an estate. In practice, bond deposits were mandated in almost 85% of cases reviewed. The average bond levied was $10,000 and constituted an average of 13% of the estate value. Although most bond deposits waived by the court were in cases of estates less than $25,000, there were several notable exceptions. One guardian assuming an estate worth $250,000 was charged no deposit. The two judges presiding over guardianship hearings levied bond deposits inconsistently. One judge handled two-thirds of all cases but charged bond deposits averaging only 10% of the estate value. A second judge, presiding over one-third of the cases, charged bond deposits averaging 25% of the estate value (difference between the judges was significant at the .005 level, using chi-square analysis).

Almost all guardianships established were provided for both person and property. In only one case was a limited guardianship option utilized to establish guardianship of property. In this case, the ward was living with a close relative (not the guardian of property), who supervised personal needs but was apparently unwilling to oversee financial management of the estate. In many cases, the examining committee's incompetency decision was predicated on a finding of either mental or physical incompetency. In relatively few cases were both physical and mental incompetency cited by the committee. It appears likely, then, that, at least in several cases, the ward would be capable of circumscribed responsibilities, such as looking after his or her self-care needs.

One 82-year-old woman, for example, was adjudicated incompetent because she could "not manage business relationships" and was "forgetful." The examining committee made this decision based on the diagnostic finding of primary senile-onset degenerative dementia, uncomplicated, without delirium, delusions, or depression. This diagnosis suggests an absence of psychotic ideation or other debilitating symptoms that might prevent the ward from caring for herself, given minimal supervision. In another case, an incompetency hearing determined that an 80-year-old ward manifested physical disabilities, based on the examining committee diagnosis of obesity, a recently broken hip, ostearthritis, and senile dementia. Here, the ward's intellectual functioning or ability to manage her own estate was apparently not addressed by the court, yet a plenary guardianship was established.

As noted earlier, most appointed guardians were relatives of the ward, many of whom were presumably serving as de facto guardians. Relatives were significantly more likely to assume guardianships when the size of the estate was greater than $50,000. Of these cases, 80% of guardians were relatives, whereas only 60% of estates less than $50,000 were supervised by relatives (difference significant at the .005 level, using chi-square analysis). Only one guardianship case in the sample was contested; this action was taken by relatives of a ward who had both assumed partial responsibility for her estate prior to the guardianship hearing.

The correlation between the size of the estate and the assumption of guardian responsibilities by a relative may be consistent with Alexander and Lewin's finding (1972) that guardianship serves the interests of third persons rather than those of wards. The correlation provides some empirical support for a theme suggested in a psychiatrist's observation that " 'for every $100,000 in a given estate a lawyer shows up, for every $25,000 a family member shows up' " (Schmidt et al., 1981, p. 104).

Financial reviews of established guardianships in Leon County were almost nonexistent. Although annual accountings of each estate are required by law, only one financial review was included in our sample. Several activities were noted in this case: 1) two medical doctors serving on the incompetency examining committee saw the patient two or three times each during the year subsequent to establishment of the guardianship; 2) a private psychiatrist was also paid to examine the ward every 3 months for a "stabilized" psychiatric condition; 3) petitioner's attorney fees totalled $1,369 and were charged to the ward's estate; 4) the newly-appointed guardian charged $2,819 for "reimbursement of administrative costs"; 5) a total of $17,000 was charged to the ward's estate in the first fiscal accounting, including $1,200 in interest for a loan.

The Dade County Grand Jury (1982) similarly found that personal annual reports were not up to date 87% of the time, 75% of the guardianship cases did not have timely financial reports, and the required physical examination reports were absent in 91% of the cases. Such practices in Miami interfered for 2 years with the discovery of a 92-year-old woman "living in squalor" (Dade County Grand Jury, 1982, p. 29) in an adult congregate living facility owned by her guardian, in violation of Florida law, despite a $150,000 bank account. In another Miami case undiscovered for 2 years, a lawyer for a ward was also appointed as guardian and then submitted "identical billings for the same functions in both capacities in the amount of $77,000" (Dade County Grand Jury, 1982, p. 30). One of the billings to the estate was $1,018 for 3 hours spent purchasing a $200 clock for the ward.

The average duration of time for adjudication of incompetency in Leon County was 35 days. Although the examining committee submitted its findings 23 days after the incompetency petition was filed, the court spent an average of about 12 days before actually acting on the incompetency issue. In six of the 42 cases, the order adjudging incompetency was signed subsequent to the petition for appointment of a guardian by an average of 15 days. Here, despite a legal presumption of competence, the court allowed petitioners to file guardianship papers prior to a ruling on the incompetency issue, but it did not date or serve notice on these petitions for appointment of a guardian until after an incompetency ruling had been promulgated. In 82% of cases examined, the petition for guardianship was filed simultaneously with the incompetency ruling. In 73% of cases, the court order appointing a guardian was issued the same day as the incompetency ruling and guardianship petitions. For the remaining 27% of cases, guardianships were ordered on an average of 15 days after the petition was filed. Cases involving small estates were litigated more rapidly. Elapsed time between guardianship petitions and appointment of guardians in cases involving estates of $50,000 or more averaged about 9 days, and elapsed time for estates of less than $50,000 averaged about 3 days (difference significant at the .01 level, using chi-square analysis).

Summary and Recommendations

Guardianship in north Florida served an elderly population suffering from age-related disorders such as organic brain syndrome and senility. Typically, guardianship serves female wards residing in private homes, who were provided court-appointed supervision by relatives living in the vicinity. Wards tended to be moderately wealthy, although the value of estates varied considerably.

Incompetency and guardianship proceedings were not conducted as rigorously as criminal, forensic, or other civil mental health proceedings. Notification of impending hearings mailed to alleged incompetents did not allow adequate time to challenge petitioners' evidence in some cases, and whether legal counsel was regularly appointed by the court is unclear. Hearings were essentially non-adversarial in nature. The court appeared to intervene minimally, allowing medical examiners full discretion to establish the incompetency of the prospective ward.

Neither attorneys nor judges challenged the nominal and inexplicit evidence presented in support of incompetency petitions or the similarly terse medical diagnoses submitted by examining committees in support of incompetency rulings. In both cases, the judiciary appeared to endorse evidentiary standards of incompetency that were insufficient, according to Florida Statutes Section 744.331(1). As a result, the behavioral incapacities of individuals adjudicated incompetent remain sketchy. Compliance with statutory guidelines might be expedited by the use of more careful (written) instructions to the examining committee and a revision of the examining committee report format. At present, this format attempts to solicit diagnostic information by asking examiners to provide evidence of incompetency. The failure to present the minimum statutory criteria for incompetency in the examining committee report encourages the committee's reliance on psychiatric rather than legal definitions of incompetence. The former are most accessible to medical/psychiatric personnel who serve on the examining committees but are less helpful to the court than legal or more functional definitions of behavior.

The appointment of guardians in north Florida appears to be an unexceptional process, often involving close relatives of the ward and formalizing supervisory relationships that have actually been in practice for some time. Consistent with Alexander and Lewin's (1972) findings, relatives in our study appeared to be more willing to involve themselves in guardianships when a large inheritance was apparently at stake. In the majority of cases, guardians were available to the court at the initiation of the incompetency petition. For these cases, guardianship hearings were quite streamlined and often were held on the same day as incompetency hearings. In a minority of cases, additional time elapsed. In all cases, the selection of a guardian appeared to be noncontroversial.

The court did not choose to appoint limited guardianships, even when wards appeared capable of caring for themselves or when they were physically incapacitated but able to make financial decisions regarding their estates. The court's reluctance to invoke limited guardianship provisions may be due in part to the fact that examining committees insufficiently appraised and documented functional disabilities of prospective wards. However, little effort was exerted to gather additional information (e.g., by contacting relatives or friends knowledgeable about the ward's physical/mental condition) that might have clarified the need for limited guardianship.

Financial reviews of guardianship were inadequate. Having established guardianships, the court is obliged to see that exploitation and irresponsible management of the ward's person and estate are avoided. This obligation is enumerated by the Florida guardianship statute in two areas. First, it is the duty of the guardian to provide affirmative treatment to the ward, pursuant to rehabilitation or restoration of competence (Florida Guardianship Law, Fla. Stat. § 744.367, 1983). Second, it is incumbent upon the court to encourage the guardian's financial accountability and judicious use of the estate's assets (Florida Guardianship Law, Fla. Stat. § 744.311, 1983). Currently the court is monitoring neither area. Guardians negligent in presenting yearly fiscal accounting to the court have not been notified or sanctioned, and the court has evidently not audited even the few accountings that have been returned.

An attempt to remedy this situation might include the expansion of the probate court clerk's office activities in order to enable more comprehensive supervision of legal guardianships. One function of the office would involve the development of a uniform estate review format to be used by court-appointed guardians. Presently, each guardian is asked to prepare annual reviews without clear guidelines detailing expected contents, length, style, and the like. Uniform review formats would standardize the documentation and subsequent judicial review processes. In addition, they would serve to delineate statutory parameters of supervision and treatment, including medical and psychiatric care and financial management of the estate. Another function of the expanded clerk's office would be to disseminate annual review forms (well in advance of deadlines) and to train guardians to compile these reviews accurately.

Perhaps most importantly, the clerk's office would serve to evaluate guardianships on an ongoing basis. For this purpose, the office might enlist the services of social workers or paralegal staff who would help to advise guardians in means of complying with treatment and financial guidelines of the Florida guardianship statute. For those guardians refusing to comply with judicial standards, the clerk's office would recommend appropriate sanctions to be levied by the court. A public guardianship office might carry out the same functions. Such an office might also assist the court in locating relatives, friends, or interested individuals or agencies in the community who would consent to supervise limited guardianships. The probate court is currently ill-equipped to survey eligible members of the community for this purpose due to its lack of contact with social resources and conclusory information provided the court by the examining committee concerning the ward's mental and physical incapacities.

This study of guardianship is limited by the small number of cases, in an essentially archival review, over a relatively brief period of time in one county of north Florida, although it did cover all of the guardianship cases in the county of Florida's capital, Tallahassee, during a 5-year period. The significant findings are similar to contemporaneous results found by a grand jury in more cosmopolitan south Florida, and the Florida findings do not differ significantly from Alexander and Lewin's (1972) New York study. The Florida findings are consistent with the opportunities for disservice in guardianship, about which considerable consensus appears in the available literature.

The literature and empirical research on guardianship to date suggest that contemporary problems may go beyond administrative bromides to the design and structure of guardianship itself. Existing commentary is replete with statutory suggestions aimed at making eligibility criteria more behavioral and less categorical and at enhancing procedural protections. The literature also identifies opportunities for judicial remedies and pleads for education and training. The suggestions for reform remain appropriate.

References

Alexander, G. J., & Lewin, T. H. D. (1972). *The aged and the need for surrogate management.* Syracuse, NY: Syracuse University Press.

Axilbund, M. (1979). *Exercising judgment for the disabled: Report of an inquiry into limited guardianship, public guardianship, and adult protective services in six states (executive summary).* Washington, DC: American Bar Association Commission on the Mentally Disabled.

Dade County Grand Jury (1982). *Final report of the grand jury.* Miami, FL: Office of the State Attorney.

Florida Guardianship Law, Fla. Stat. §§ 744.102(5), 744.303, 744.311, 744.311(1), 744.331(5)(a), 744.367 (1983).

Horstman, P. (1975). Protective services for the elderly: The limits of parens patriae. *Missouri Law Review, 40,* 215–278.

In re Guardianship of Paunack, 355 So.2d 1195 (Fla. 1978).

Mitchell, A. (1979). The objects of our wisdom and our coercion: Involuntary guardianship for incompetents. *Southern California Law Review, 52,* 1405–1449.

Regan, J. (1981). Protecting the elderly: The new paternalism. *Hastings Law Journal, 32,* 1111–1132.

Regan, J. (1982). Adult protective services: An appraisal and a prospectus. In *National Law and Social Work Seminar: Proceedings and Prospects* (pp. 12–19). Portland: University of Southern Maine.

Regan, J. J., & Springer, G. (1977). *Protective services for the elderly.* Washington, DC: U.S. Senate Special Committee on Aging, 95th Congress, First Session. (mimeo)

Report of the task panel on legal and ethical issues (1978). In *President's Commission on Mental Health* (Vol. 4). Washington, DC: U.S. Government Printing Office.

Sales, B. (1979). *Guardianship and conservationship: Statutory survey and model statute.* Washington, DC: American Bar Association Commission on the Mentally Disabled.

Schmidt, W. (1981). Guardianship of the elderly in Florida: Social bankruptcy and the need for reform. *Florida Bar Journal, 55,* 189–195.

Schmidt, W., Miller, K., Bell, W., & New, E. (1981). *Public guardianship and the elderly.* Cambridge, MA: Ballinger Publishing Co.

Sherman, R. (1980). Guardianship: Time for reassessment. *Fordham Law Review, 49,* 350–378.

Solender, E. (1976). The guardian ad litem: A valuable representative or an illusory safeguard? *Texas Tech Law Review, 7,* 619–643.

BLANK PAGE

Begin the session with the following exercise. Ask students to list eight things that they most enjoy doing (i.e., reading, sewing, going to the movies, jogging, etc). Next, tell them to cross out things that they would have to give up if

a) they were out of work and could only afford the bare necessities

b) they lost their best friend

c) their vision declined

d) their hearing declined

e) their appetite decreased (taste sensitivity lost), dietary necessities changed

f) they had reduced mobility (i.e., arthritis)

g) they had to care for elderly parent full time

h) they lost significant other

What is left? Discuss. How dependent are we on good health, strength, and other people? What are some possible implications of this for our own future?

The first hour of this session can be used to review the student case studies. Each case presented should be assessed along the guidelines noted in Section IV of this chapter. Time will probably not allow for more than one or two presentations. The instructor can refer to this chapter in subsequent weeks. Whenever time permits, one or two cases can be reviewed by the class.

The instructor should keep in mind that some of the material in this section is a review of material presented in the chapter on normal aging. More time, therefore, can be devoted to discussion of the impact that social losses can have on the mental health of an older person. Attention should also be drawn to the fact that the elderly rarely suffer losses in only one area of their lives. Losses in one area will usually result in losses in other areas of a person's life.

This chapter is the first one that allows for a discussion of the grief process. It is very important for you, as leader of discussions, to be very aware of your own feelings about death and bereavement. It might be helpful to announce, in the previous session, that death and grief will be the next topic. As the instructor you should be prepared to allow plenty of time for group discussion. Some of the participants in the class may have suffered a death of someone close to them. Once the topic of death has been opened they may feel compelled to talk about their experiences and an open and supportive atmosphere should be maintained.

When you are reviewing the phases of grief, alert your students to the fact that the bereavement process may take a longer period of time for an older person than for a younger person. One reason for this is that the current loss may be the latest in a series of losses or may be causing other losses in the person's life.

In 1969, Elizabeth Kubler-Ross presented a framework for understanding the process of dying and this framework can also be used in discussions of grief. The stages are:

1. Denial
2. Anger
3. Bargaining
4. Depression
5. Acceptance

Kubler-Ross's model is currently being challenged because of poor research design. The greatest value of her work, nevertheless, may be an increased sensitivity to the needs of the dying and those who are grieving over a loss.

BLANK PAGE

DEFICITS AND LOSSES

Name: ______________________________ **Date:** ________________

CIRCLE THE CORRECT ANSWER.

1. The "empty nest" syndrome is the popular name for:
    - a. hysteria
    - b. a cognitive deficit
    - c. a social loss
2. With age, crystallized intelligence tends to:
    - a. increase
    - b. remain the same
    - c. decrease
3. Although the majority of elderly learn to cope with the losses that accompany the aging process, some experience mental health disorders, and a common functional disorder among this group who have hearing loss is:
    - a. paranoia
    - b. kleptomania
    - c. schizophrenia
4. In the grieving process, a normal first reaction to the death of a loved one is:
    - a. anger
    - b. guilt
    - c. denial
5. As young people set up independent households, the opportunities for mutual dependence and respect among generations:
    - a. increase
    - b. remain the same
    - c. lessen
6. Men who become widowed:
    - a. tend to remarry
    - b. commit suicide
    - c. move in with their children
7. Contrary to popular belief:
    - a. older people cannot learn new material
    - b. older people can learn, it just takes longer
    - c. older people can learn new things, but do not want to

8. The suicide rate for the elderly is:

   a. 25% higher than the general population
   b. half that of the general population
   c. 3 times higher than the general population

9. The largest amount of poverty in old age is seen among:

   a. married couples
   b. single men living alone
   c. minorities and women

10. What percentage of elderly have one or more chronic physical conditions?

   a. 11%
   b. 85%
   c. 40%

Deficits and Losses

1. c
2. b
3. a
4. c
5. c
6. a
7. b
8. c
9. c
10. b

BLANK PAGE

Aging

ROGER L. PATTERSON AND JAMES R. MOON

Introduction

Older people are subject to almost all the problems that younger people may have, and younger people may have most of the problems that older people may have. Therefore, all the techniques of behavior therapy are potentially applicable to older as well as younger people. Yet, there is merit to attending especially to an elderly group in a book such as this. Much of this merit derives from the fact that the typical elderly person in need of behavioral intervention may present quite differently to the therapist than does the typical younger person; and those therapists not knowledgeable specifically about working with the elderly may find themselves at a loss as to the best way to proceed. In this chapter we will present the differences a behavioral therapist will typically encounter between elderly and nonelderly clients. Next, we will describe the process whereby events related to "old age" can produce problems. Then we will present the behavioral approach developed at the Florida Mental Health Institute to help the elderly client overcome these problems. Finally, we will present two case studies that illustrate the application of the behavioral approach to two problems commonly encountered by the elderly.

The first difference encountered is in defining and assessing the problems for which intervention is desired. A simple self-report of problem definition as gathered in a few sessions is not easy to obtain and may well be insufficient when it is obtained. Furthermore, factors affecting the elderly are many, and they are com-

ROGER L. PATTERSON • Director, Geriatric Rehabilitation Project (116B), Veterans Administration Medical Center, Tuskegee, Alabama 36083. JAMES R. MOON • Department of Aging Programs, Florida Mental Health Institute, The University of South Florida, Tampa, Florida 33612.

plexly related. Both the assessment and the interventions will probably have to take into account several variables affecting the behavior.

Two major classes of factors that must be considered are physiologically based problems and environmentally based problems. Physiologically based problems include illness and may also include developmental changes, such as a variety of sensory changes and a decrease in response speed. With regard to illnesses, more than 40% of the elderly people beyond the age of 65 have some limitations of their activities caused by chronic diseases, such as arthritis or hypertension (Kalish, 1975). Some illnesses may have psychological impact by direct effects of the disease on cognitive functioning. Illnesses may also produce indirect effects by producing distracting chronic pain or by restricting the mobility of the individual and thus limiting the individual's exposure to environmental cues, prompts, and reinforcers. Even more indirectly, illnesses may cause the victim to perceive of himself or herself as being a less powerful, less effective person.

The dementias are illnesses that deserve special attention because they may produce profound direct effects on all functions. The reader is probably most familiar with the Primary Degenerative Dementia that is usually caused by Alzheimer's disease and causes gradual but steadily decreasing losses of intellectual functioning, usually over a period of years. This latter disease is currently untreatable, though some types of interventions may help to alleviate its effects (Yeasavage, Westphal, & Rush, 1981).

Multi-infarct Dementia is a second type of dementia that is produced by a series of arterial hemorrhages in the brain. This disease may progress in a sequence of rather sudden losses of functioning. Some recovery may occur after each loss. Medical treatments aimed at improving the functioning of the cardiovascular system may help to prevent such strokes.

Sensory losses are frequently found in elderly persons. More than 40% of the elderly between the ages of 60 to 89 report hearing loss (Maurer, 1976). A variety of visual impairments is also frequent (Gordon, 1974). Changes in taste and smell may also occur, though these are less well documented (Carroll, 1978). Perhaps it is obvious that changes in vision and hearing may make communication and continued mobility more difficult. It may be less obvious that any sensory deficit may serve to weaken many behaviors by reducing *both* the effectiveness and frequency of occurrence of many prompts and reinforcers.

Like the physiologically based changes, changes in the environment of the elderly person are often of considerable consequence. The issue of psychosocial losses is often discussed in gerontology. Retirement and/or the end of the active parenting role may produce important losses. For most people retirement produces an economic loss as well as the loss of numerous relationships and a certain status in life. Also lost are the important routine and organized activities required for work and many social arrangements. Retirement may present no important problems for most people, but the potential for problems is present. Any clinician working with retired people will likely soon confront some retirement-related difficulties. Many of these difficulties are related to the rather massive loss of prompts and reinforcers that retirement represents. Probably, most nonretired adults organize their lives around their own employment and/or that of their spouses. The number and potency of antecedents and consequences (economic as well as social) that the workplace offers to promote competent, organized prosocial behavior is large. If these are terminated and no adequate system exists to continue to replace prompts and reinforcers for desirable behaviors, then great and often undesirable behavioral changes are to be predicted.

Other kinds of psychosocial losses that are frequent for the elderly are the partial or complete losses of interaction with spouses, friends, relatives, and social organizations. Such losses may be caused by death, illness, loss of mobility, or simply by relocation. These losses, if not replaced somehow, may produce important decreases in cues for desirable behaviors as well as social reinforcement for maintaining important desirable behaviors.

A final type of environmentally based problem that may exist only in certain environments has been demonstrated by Baltes and her associates (Baltes, Burgess, & Stewart, 1980). These authors made systematic observations of the behavior of residents and staff in a nursing home and found that the staff often either actively or passively discouraged residents from exhibiting social and self-care skills.

The reader must by now have recognized that many of the factors described here carry the risk of producing less competent behavior on the part of an elderly person and thus causing problems. Before discussing this matter further, however, it is necessary to reiterate that most elderly people probably never experience severe problems from most of the factors discussed. It is true that most people may never experience dementia and most people may adapt well to retirement. Although most may experience some losses, such as sensory deficits and losses in reaction time and strength, these losses may not be experienced as distinguishable problems in living.

In clinical practice, however, it is extremely likely that the clinician working with the elderly will see people who are experiencing problems that are related to the preceding factors in rather complex ways. It is necessary that the clinician be aware of the possible operation of such variables in every case. As will be discussed later, the assessments need to be adequate to detect or discount the operation of the variety of physiological and/or environmental conditions that may account for particular problems. Likewise, an awareness of these conditions is needed in order to develop suitable interventions. This does not mean that the behavioral practitioner must be qualified to obtain all the needed information firsthand. For example, few behavior therapists practice general or internal medicine so as to be able to ascertain directly the existence or nature of many physical conditions. In most cases, it does mean that the practitioner must be able to obtain from some source the relevant information regarding such conditions and their impact on behavior.

Description of the Disorders

Major reasons for referral are often a lowered level of self-care accompanied by poor social functioning. The clients will often be unhappy, if not clinically depressed, and tend to blame their problems on physical illness and/or other people who are said to mistreat them. There is very little if any awareness of psychological problems. Anxiety may often be present and recognized by clinicians; however, elderly clients often refer to anxiety as "nerve problems," which are thought of as a physical defect. There is very little awareness that elderly clients can do anything to improve their lives.

With cases such as this, relatives, friends, and even many professionals may have a perception of the client's problems, which is similar to that of the client. That is, the affected person may be seen as merely suffering from the problems of "old age" that are basically physical in nature. Thus "old age" is not a problem; rather, the lowered level of self-care and poor social function are the problems. The task of the behavioral clinician is therefore to identify and address the multiple sources that combine to produce these problems. In this way the behavioral clinician utilizes his or her training to help the client. The concern of well-meaning but unenlightened potentially helpful people may be with humoring the old person by treating him or her rather childishly. The only types of meaningful assistance may be those of providing goods and personal assistance with specific tasks. Although some forms of the provision of goods and personal services may be useful or even necessary, they may be given in such a way so as to serve to increase dependence, lower positive self-attribution, and further degrade competent behavior. Thus, many would-be helpers may actually become part of the problem by maintaining helpless and hopeless concepts and helpless behaviors, rather than assisting the older person to maximize his or her competency and self-respect.

Assessment

The multiplicity of problems that might affect the behavior of an elderly person is something that may not often confront the therapist accustomed to working with most younger adults. Indeed, most therapists not working with the elderly may be accustomed to looking only at well-defined problems rather than a more global assessment of the person and his or her situation in life. After all, when one is afraid of flying in airplanes, a global assessment is not really required. However, for the reasons just discussed, a multifaceted assessment of environmental/social factors and medical/physiological problems is needed to develop adequate interventions for the elderly. The assessment process and techniques described here is an example of such a comprehensive assessment. It was developed by the Residential Aging Program (RAP) of the Florida Mental Health Institute over a period of 8 years. Treatment interventions described later also took place in RAP. (An earlier version of this program and its evaluation has been described extensively by Patterson, Dupree, Eberly, Jackson, O'Sullivan, Penner, & Dee-Kelley, 1982.)

RAP uses a number of standard assessments both for the initial assessment and for measures of progress. These are of several types; they serve several different purposes and are described next.

One of the first assessments administered is the Functional Assessment Inventory (FAI). The FAI is a structured interview technique developed by Pfeiffer, Johnson, and Chiofolo (1981) to reliably and validly assess an elderly client's assets and deficits in five important areas. The areas assessed are social resources, economic resources, mental health, physical health, and activities of daily living (ADL) abilities. The FAI as such is primarily a self-report technique, although it contains provisions to obtain data from an informant if the client is judged to be an unreliable source. The FAI is useful in that it provides a structured and standardized interview technique that elicits valuable information about a client in a variety of areas.

The FAI contains a brief and useful mental status examination, the Short Portable Mental Status Questionnaire (SPMSQ) (Pfeiffer, 1975). The SPMSQ consists of 10 simple questions regarding time, place, and person. Validity data have been supplied by Pfeiffer (1975) that show that persons missing more than 4 questions are probably suffering from dementia of some type.

Two behavior-rating scales are completed by the staff in order to obtain global and relatively comprehensive descriptions of problems and areas of competence. In the residential setting, both of these are completed by the direct-care staff on the evening shift. One of these scales, the Missouri Inpatient Behavior Scale (MIBS) (Sletten & Ullett, 1972; Missouri Psychiatric Institute, n.d.) was designed to measure a great variety of behaviors considered to be psychiatric symptoms. These behavioral ratings on 90 items were grouped together based upon factor analyses and rational considerations to form 11 subscales. Seven of these relate to problem areas, and 4 are competency related. The seven problem scales include Hostility, Excitement, Anxious Depression, Regression, Paranoid Thinking, Confused Communication, and Withdrawal. The competency-related scales include Social Competence, Work Competence, Personal Competence, and Activity (appropriate). Each of these scales measures what the title suggests. The MIBS is useful for identifying particular broad areas of problem behavior. Based upon such identification, more specific observations may be made to identify target behaviors for intervention. The MIBS also measures changes in behavior over time.

A second useful behavior rating scale is the Community Adjustment Potential Scale (CAPS) of the Discharge Readiness Inventory (Hogarty & Ulrich, 1972). The CAPS was designed to predict postdischarge adjustment. It contains 30 items generally pertaining to personal and social competencies that are needed in community life. The CAPS provides a very useful summary of the general ability of the client to lead a normal community life.

Three self-report inventories are included to measure three problem areas that are frequently found among elderly persons but that require self-report. These three measure anxiety, depression, and personal well-being (life satisfaction). Although the behavior rating scales can measure overtly observable behaviors related to anxiety and depression, we feel that self-report is a crucial element of these problems. The rating scales measure behaviors rather grossly. Personal well-being can probably be measured only by self-report.

The anxiety measure is a special form of the State-Trait Anxiety Scale for children (STAIC) (Spielberger, Edwards, Lushene, Montouri, & Platzek, 1973), validated for use on mentally ill elderly by Patterson, O'Sullivan, and Spielberger (1980). The reason that a special validation was done is that the adult form of this scale proved difficult for many elderly persons to complete. The children's form is much easier to use and appeared to provide similar information. However, specific validity data were needed to assure the appropriateness of the latter scale. Anxiety may be a major problem for many elderly (Kalish, 1977; Kuhlen, 1959). Therefore this variable should be assessed.

The Beck Depression Inventory (BDI) (Beck, 1979) is used as the self-report measure of depression. It contains 21 items. Each item consists of four statements of which the client is to select at least one. Depression is widely noted to be a frequently found problem among the elderly. Therefore, an assessment of this type is made on all RAP clients.

Life satisfaction or subjective well-being is one of the more frequently discussed concepts in the gerontological literature. RAP assumes as one of its therapeutic objectives the improvement of life satisfaction. The Life-Satisfaction Index (LSI) (Neugarten, Havighurst, & Tobin, 1961) is the oldest scale used for this purpose and has been repeatedly demonstrated to be quite useful (Larson, 1978). Therefore, RAP includes the LSI as a standard assessment.

Much of the effort of RAP is devoted to assessing and remediating specific deficits in the behavior of the elderly clients. Deficits are often found in the ability of these individuals to care for themselves, their environment, and their belongings. Such self-care activities are often called *activities of daily living* or ADL (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963). Other areas of deficits are more social in nature. The old person may have a low rate of social interaction or may try to relate ineffectively or inappropriately. Some clients do not know significant personal information, such as their location, the names of their doctor and therapist, and so forth. Others may have difficulty finding their way around. RAP employs assessments to identify and interventions to remediate all these problems.

Several of the behavior-rating scales described here do include measures of ADL, social behaviors, and personal competence, but these measures are usually too global to describe target behavior or to provide sufficient information as to the effectiveness of specific interventions. For these reasons, other measures have been developed. These are called *modular assessments* because they are used directly in conjunction with training modules designed to overcome these deficits. Patterson *et al.* (1982) and Patterson, Penner, Eberly, and Harrell (1983) report reliability and validity data on most of the modular assessments.

Modular assesssments developed to measure ADL were divided into three levels. ADL I measures personal hygiene. Upon admission, each client is observed according to a standard protocol once each week to determine if his or her grooming is acceptable. Areas assessed include oral hygiene, bathing, hair care, face care (shaving or cosmetics), clothing cleanliness and appearance, and nail care. If deficiencies are noted, then further assessment of the client's ability to perform the activities needed to correct the particular grooming deficit(s) is performed. These assessments are basically task analyses; for example, "Obtain oral hygiene materials"; "Applies toothpaste to brush," and the like. The clients are asked to perform the tasks while being observed to determine whether they can do so independently, with verbal assistance, with modeling, with occasional physical assistance, or if they require complete physical assistance.

ADL II is concerned with the client's ability to take care of laundering needs, choose meals, care for own room and bath, and use the telephone correctly. The clients are observed to see if they can perform these chores independently and correctly.

The ADL III assessment concerns budgeting time and money, community resources, meal planning and preparation, and housekeeping. It is an interview which clients are asked four questions within each area to determine if they have sufficient knowledge regarding these areas.

Two social skills assessments are used. One is a time sample of how frequently the clients are observed to converse appropriately when seated in a group and directed to converse. A second assessment is devoted to measuring the client's ability to utilize verbal and nonverbal behaviors appropriately in order to communicate effectively. This Communications Assessment consists of a rating scale on which ratings of several behaviors are made based upon observation of a roleplay. The behaviors rated include (a) content (what was said); (b) speech volume; (c) voice quality; (d) facial expression (including eye contact) (e) hand gestures; and (f) body position. A seventh rating is a global rating of all aspects of the performance. All ratings are made on a scale of 1 to 6 with 1 indicating inappropriate behavior or complete absence of behavior, and 6 indicating a completely correct performance that was delivered with a high degree of emphasis and enthusiasm. The two roleplay situations used for the assessment are one that calls for the expressions of pleasure and/or gratitude to another person, and another that calls for the appropriate expressions of displeasure combined with a request that another person correct an undesirable situation.

An assessment known as Memory Development (MD) (Bernstein & Dvorkin, 1978) is included to identify needs of clients in the area of personal orientation. Two parts to this assessment, as routinely used, are Personal Information (PIT) and Spatial Orientation (SO). PIT assesses the clients' abilities to supply on demand their name, address, telephone number, the name of a person who can speak responsibly for them, and the name of their therapist. SO assesses the clients' abilities to find, from the day room, the way to their room, the bathroom, the kitchen, the telephone, and the cafeteria. Clients are asked to demonstrate that they can do this while being observed.

In addition to the aforementioned rather structured assessments, it is necessary to obtain information about any idiosyncratic problem behaviors that a client may exhibit. Desired information includes a description of the behavior, the apparent antecedents, the immediate natural consequences, when and where the behavior occurred, and the information about others present. Frequency counts of the behaviors are also needed. In order to gather this information routinely, a Behavior Analysis Form (BAF) has been developed and made available to all staff at all times (see Patterson *et al.*, 1982). This form is divided into three sections: antecedents, behavior, and consequences; and it contains labeled space for all information described previously.

Other critical assessments are less formally structured than those cited before and are more traditional in nature. However, these latter assessments are critical to working with most elderly clients having more than minor problems. These include the social history, the physical examination, and the psychiatric evaluation. The physical and psychiatric evaluations become the basis of formal diagnosis and any medical treatments. These latter three assessments require no particular areas of expertise in behavior therapy and will not be elaborated upon further here. Rather, it will be shown how data from these nonbehavioral sources are integrated with information from the behavioral assessments described previously in order to finally determine the list of problems that should be addressed for any client. Thus, the behavioral practitioner can combine and integrate data from various sources to produce a thorough conceptualization of the problem and a behaviorally based treatment plan.

As a device for achieving this integration and also for assuring that no relevant problem area is overlooked, RAP uses a standard set of topics that identify 10 areas of potential problems. This set of topics is first addressed in the social history. The social worker is asked to get whatever information that can be obtained from the elderly client or from collateral sources regarding all these topics. As is explained next, this historical information is then integrated with the information from all of the other assessments in order to define specific problems for which intervention is required. The standard list of the 10 problem areas along with information utilized in examining each will be presented next.

Social Support System

The extent and quality of a client's social network is a very important factor to consider when evaluating a client's previous level of functioning and when planning his or her placement for long-term community readjustment. As part of the assessment of the client's social support system, his or her marital status and marital history are determined by the interviewer. Additionally, the client's current living arrangements are evaluated. Finally, the client's previous and current involvements in social clubs, organizations, and other support groups are determined.

Economic Resources

When the interviewer determines the client's economic resources, several different areas are examined. The client's educational history is taken as well as the client's vocational history. His or her current economic resources are evaluated in terms of income (Social Security, pension, vocational income, etc.), expenses, and other assets such as real estate, insurance policies, investment income, and the like.

Legal Problems

The client's current legal status is ascertained, and any current or pending legal actions are assessed. When necessary, the client is provided with referrals for legal assistance.

Self-Defined Problems

The client is asked to list or report current problems that he or she would like to solve during treatment. No restrictions are placed upon the types or amount of problems the client lists. Additionally, the client is given the opportunity to specify his or her treatment goals. The client's self-defined problems and goals then become an integral part of his or her treatment plan.

Mental Health History

During the social history interview, the client's psychiatric history is determined. The client's previous psychiatric hospitalizations, the length of stay, the precipitating circumstances, and the outcome of the hospitalizations are determined insofar as possible. The client is also interviewed about current problem(s), any hallucinatory or delusional experiences, and the precipitating circumstances. The interviewer determines the client's current level of suicidal or homicidal ideation and any previous suicidal or homicidal behaviors. The interviewer inquires into any substance abuse problems currently experienced by the client, including alcohol consumption, nicotine and caffeine intake, and the use of prescription and nonprescription drugs. Finally, various assessment scores are integrated into this section. These assessment scores are the SPMSQ score, which gives a general index of cognitive impairment (Pfeiffer, 1975); the BDI score (Beck, 1979), which provides a self-report of depression; the special form of the STAIC (Patterson & Jackson, 1980), which gives a self-report of anxiety; and the MIBS and CAPS scores, which give objectively obtained data on a number of different adaptive and maladaptive behaviors. Although these scores are first reviewed in this section, information from them is often used to indicate progress in overcoming skill deficits.

Maladaptive Behaviors

The kinds of behaviors that have caused problems for the client in the past are determined by the social history. Also, any problem behaviors observed by the staff (BAFs) are included. These include behaviors such as excessive isolation, agitation, confusion, lack of appetite, sleep disturbance, and the like.

Physical Health Status

The information gathered by the social history interviewer is combined with the information gathered by the medical staff to provide a comprehensive understanding of the client's physical health status and the limitations that may be placed upon him or her by poor physical health. In addition, the medical staff provides an explanation of the client's current medications and the probable effects of these medications upon behavior.

Social/Leisure Activities

Clients are asked to report leisure and avocational interests and activities in order to provide information regarding their utilization of unstructured time.

Additionally, clients' use of unstructured time since admission to the program as reported by routine staff observation is evaluated.

Placement Issues

The client's most recent placement is ascertained. In addition, the interviewer determines the client's most desired placement and the most likely placement upon discharge. Placement is considered with respect to the client's level of independent functioning, income, and the likelihood of continued community placement. Independent living and adult congregate living facilities (boarding homes and foster placements) with appropriate mental and physical health follow-up are the most frequent placements. Placements to more restrictive facilities such as state hospitals, crisis centers, or nursing facilities are discouraged unless absolutely necessary.

Summary

Thus, the standard problem list organizes a complex series of data into 10 functional units. The treatment staff reviews information relevant to each of the 10 sections to determine where problems exist and discusses the most appropriate treatment modality within the context of the program.

Behavioral Intervention Techniques

Very few behavior therapy techniques have been developed for use with the variety of problems of the elderly discussed here. The basic approach used in much of the literature on behavioral treatment of the elderly has been to concentrate only on extreme deficits of institutionalized groups or individuals (Patterson & Jackson, 1980). Most published studies have succeeded in establishing that the behavior of such elderly people is indeed modifiable, a point that had apparently been in doubt by many. However, almost none of these studies went beyond the point of such demonstrations in order to develop programs that could produce an important overall therapeutic impact on the subjects' lives.

An exception to the type of approach described previously was the program described in the book by Patterson *et al.* (1982). These authors developed a broad-scale behavioral treatment program that, when combined with medical and social approaches, succeeded in producing global behavioral changes in elderly people. Furthermore, important therapeutic outcomes were demonstrated. Elderly people treated in this program included not only those in mental institutions but also those still living in the community.

The behavior therapy techniques used by Patterson *et al.* concentrated on structured training groups (modules), which taught ADL, social skills, and other personal skills. These modules were complemented by behavioral interventions designed to alter idiosyncratic behaviors of specific individuals that the modules did not address.

Although apparently successful, it was noted by Patterson and his associates, during the course of the study, that many improvements could be made in the treatment modules. Also, persons treated by the program, depressed people in particular, could probably benefit from cognitive behavioral approaches similar to those developed by Beck and his associates (Beck, Rush, Shaw, & Emery, 1979).

The basis of the entire treatment program was a milieu that sought to provide social reinforcement and verbal feedback for accomplishments at every opportunity. Social reinforcement was often paired with tokens, which could be exchanged for goods, such as grooming items (cosmetics, clothing, etc.), snacks, and a few privileges. The program went well beyond the usual token economy, however, in that much of each client's day was occupied by highly structured training modules, each with its own assessment. The names of these modules were the same as those already presented in the section on assessments.

ADL Training

In the ADL I and II training, the clients met in groups if this was appropriate, and obtained or were presented with the objects or devices (nail clippers, telephones, washing machines) necessary to accomplish a particular ADL task. Brief instructions and modeling regarding the task was then presented. Clients were then asked to perform. Appropriate attempts at performing the task were reinforced according to the techniques of shaping and chaining. Additional verbal and/or nonverbal prompts and physical assistance was given only when needed. For example, a client might soak her toenails in warm soapy water preparatory to trimming them but then require assistance with using the clippers until she learned to use them.

In ADL III training, more typical classroom methods were used. The clients met in groups and were supplied with notebooks in which they were required to record information useful to them. Teaching was mainly by discussion of topics related to the target areas. ADL III was like ADL I and II, in that the emphasis was on a brief presentation by the leader with much of the training time being devoted to reinforcing responses by all the clients. Discussions were supplemented by actual practice in locating bus routes, identifying community resources, buying and preparing food, and so forth.

Social Skills Training

Teaching effective communication of pleasure and displeasure (Communications Training) required that all clients roleplay the expected behaviors and/or practice giving accurate positive feedback during each session. Clients were seated in a semicircle, with the roleplay occurring in the center. The group leader gave very explicit instructions to the role players and the other group members regarding the scene to be enacted (e.g., your neighbor cut your hedge for you and you want to express your gratitude). The group leader also made sure that all members understood the behaviors to be rated. Reinforcement was given both for improved performance and accurate positive feedback.

Conversation training occurred in a day-room area with chairs arranged facing each other in groups of four. Clients were instructed to converse appropriately. Observers time sampled the conversation and reinforced appropriate conversers on a variable interval schedule, averaging one reinforcement every 5 minutes.

Self-Esteem Training

Clients found to have low levels of personal well-being, as measured by the LSI, have been found to benefit from a training module called *self-esteem training*. Clients meet in groups to learn to recognize and claim positive characteristics of themselves. As with other modules, the leader has the task of prompting group members to make appropriate positive statements regarding themselves, and the leader must also reinforce properly such statements where they occur. As part of the process, the group members are also taught to socially reinforce other group members for such statements. All negative self-references are placed on extinction by being ignored.

Memory Development (MD)

Consistent with the MD assessment, two skills areas are taught in the MD training module: (a) any deficits in personal information (PIT); and (b) any deficits in the ability to locate the designated areas (SO). PIT training is accomplished by using reinforced practice of prompted verbal responding and mnemonics. As with other modules, the skillful fading of prompts is required. In this case, prompting may be done by giving the client several possible responses and requiring him or her to repeat the corrected one, or supplying part of the correct answer. Mnemonics used include semantically relating the new information to old memories ("The address is 30th Street, just like 30 days has September") making rhymes, and others.

SO training is accomplished by backward chaining. Clients are led to the furthest point from which they can find the location. They are then reinforced for reaching the destination. The distance from the location is then increased on subsequent trials. MD training is conducted individually three times daily until it is no longer required, or until it becomes apparent that it will not work.

Cognitive Therapy for Depression

The interview of the depressed client reveals the manner in which he or she thinks about the self, the environment, and the future. Typically, the client's thoughts will be distorted in any one of several characteristic fashions. Beck *et al.* (1979) identify five types of cognitive distortions: arbitrary inferences, selective abstractions, overgeneralizations, magnifications or minimizations, and inexact labeling. Additionally, these depressive distortions tend to be automatic, involuntary, plausible, and persistent.

The elderly client must be given a rationale for therapy. The rationale should be as complex as the client's intellectual abilities will allow (e.g., from "This will be

BEST COPY AVAILABLE

a time for you to tell me what's on your mind" to "We will identify your depressive self-statements and help you change their maladaptive characteristics"). Clients are then informed that thoughts or cognititions can influence the way they behave and "feel." When the client accepts the rationale, the therapist engages his or her cooperation in self-monitoring of depressive cognitions.

The client's willingness and ability to detect automatic depressive cognitions is essential for successful cognitive intervention. As the client identifies the distorted depressive cognitions, the therapist clarifies and then corrects the distortions. The therapist continues to correct the cognitive distortions until the client begins the process of self-correction. This process is accomplished via fading of therapist correction while simultaneously rewarding (through verbal reinforcement) the client's self-correction.

As the client becomes more adept at self-correction of distortions, the therapist intervenes in a new fashion to encourage him or her to increase the amount of positive cognitions and pleasurable behaviors. When necessary, the client will be required to keep a daily log of cognitions (positive and negative) and "feeling states."

Finally, a technique described by Meichenbaum (1977) is utilized to *inoculate* the client to future depressive stressors. After the depressive episode has remitted, the client is encouraged to prepare for future depressive episodes by describing what could cause future depressions and what he or she could do to prevent or alleviate such depressions. The client is encouraged to verbalize prevention techniques, such as regularly taking antidepressant medications and regularly engaging in pleasurable behaviors. Also, the client is encouraged to identify the signals of depression, for example, feeling "blue," loss of appetite and libido, and sleep disturbances. Lastly, the client is encouraged to identify the cognitive techniques he or she would employ to overcome the depression.

These techniques illustrate a comprehensive cognitively based psychotherapeutic intervention strategy for depression that has been useful in supplementing the other behavioral techniques illustrated in this chapter. In the elderly client who has sustained multiple sensory, behavioral, and social losses, individual psychotherapeutic techniques cannot begin to singlehandedly modify depression. However, for many elderly clients, individual psychotherapy is a useful and necessary adjunctive treatment that may help to minimize and foreshorten the client's psychological discomfort.

Summary

The RAP treatment staff administers these modular treatments and collects the data on a client's progress. The case manager periodically summarizes all of the behavioral treatment data. Similarly, the medical staff periodically summarizes medical and psychiatric treatment data, the psychologist summarizes cognitive therapy treatment data, and the social worker summarizes additional social history information. This information is presented for evaluation to the treatment team consisting of a behaviorally oriented psychologist, head nurse, unit director, social worker, psychiatrist, rehabilitation therapist, case manager supervisor, and case manager.

Thus, the treatment team periodically reviews the initial and progress assessments as the client continues through treatment and adjusts the treatment to the needs of the client. In this way the treatment team integrates information from 10 discrete areas of consideration on a continuing basis to help insure appropriate skill acquisition, which will generalize and be maintained after the client leaves treatment.

The process just described will now be illustrated with two case studies. These two cases represent two major diagnostic categories found among the elderly with mental health problems. These are depression in the case of Mrs. A., and organic brain syndrome as illustrated by the case of Mrs. C.

The Case of Mrs. A.

Social History and Treatment Development

As noted, all sources of information are presented to the treatment team for evaluation and planning. The initial treatment meeting is designed to review the social history, assessment data, and other data for the purpose of developing an initial treatment plan. Obviously, all data may not be present at the initial treatment meeting, and thus additions to the treatment plan may occur throughout treatment.

Background

Mrs. A. was a 77-year-old white female admitted to the program with a diagnosis of Major Affective Disorder–Unipolar, Recurrent. Mrs. A. was born in Georgia, where she resided until approximately 7 months ago when she moved to Florida. Mrs. A.'s husband of 60 years died approximately 1 year ago, and since his death she had progressively deteriorated by becoming increasingly depressed, irritable, and restless. She moved to Florida to live near her son and daughter-in-law, who are her primary sources of social support. Although Mrs. A. lived in her own apartment, she was extremely dependent upon her son and daughter-in-law who lived across town. She would frequently telephone and gasp, "Come get me. I'm dying!" Obviously, this behavior alarmed the son and daughter-in-law who would rush to the aid of Mrs. A., thus reinforcing her behavior. Upon entry to Mrs. A.'s apartment, they would find her tearful and complaining of loneliness but otherwise in good health.

Mrs. A. was an outpatient at a local community mental health center (CMHC) for approximately 5 months prior to admission and was taking antidepressant medication during this time. Because noticeable improvement was not forthcoming, Mrs. A., her children, and her CMHC therapist referred her to our facility for inpatient treatment.

Social Support Problems

Mrs. A.'s background information was reviewed. In addition to the aforementioned background information it was also found that prior to admission the client was living in an apartment complex designed specifically to promote social interaction among its elderly residents. Thus, the treatment team decided that the client had available social support systems in her apartment complex and also in her son and daughter-in-law. However, it was clear that she relied too heavily upon her son and daughter-in-law and not heavily enough upon the resources in the apartment complex. The treatment team recommended behavioral counseling sessions with the client and her children to decrease such dependency. Also, the team recommended increased development of the resources available at the apartment complex. As the client neared discharge she was required to spend an increased amount of time on weekend passes developing social contacts at the apartment. The client was rewarded for her efforts by visits from the son and daughter-in-law.

Economic Problems

The client had a fifth grade education but had a long history of employment in her home town in Georgia. The client's income was primarily from Social Security benefits. She had a modest savings account and was also helped financially by her children. Mrs. A. was not judged to have financial problems.

Legal Problems

Mrs. A. had no legal problems. She was voluntarily admitted and was legally competent.

Self-Defined Problems

Mrs. A. identified her problem as "the move to Florida." She wished to move back to Georgia. The treatment team decided to explore the possibility of having the client return to Georgia. The client's children were willing to assist her in this effort if she became "less dependent and depressed."

Mental Health Problems

The client reported recurrent depressive episodes since she was 35 years old following a hysterectomy. These episodes often resulted in brief inpatient hospitalizations. The depression apparently remitted subsequent to the hospitalization and the use of antidepressant medications. Mrs. A. was currently not judged to be an active suicidal/homicidal risk. There was no evidence for substance abuse, nor was there evidence for psychotic behaviors of hallucinations or delusions. Mrs. A. showed no cognitive deficits on the SPMSQ and was judged to be well oriented. She was experiencing severe depression with some somatization. Her thoughts consisted of ruminations of being alone, being afraid, having no future, and thoughts of her deceased husband. Vegetative signs of depression, including sleep and appetite disturbances, weight loss, constipation, and loss of libido were not found. The team recommended evaluation by the clinical psychologist for consideration of individual cognitive modification therapy.

Maladaptive Behavior Problems

The client adjusted well to the inpatient routine. and no maladaptive behaviors were noted. Therefore. the team recommended no special treatment with regard to maladaptive behavior.

Physical Health Problems

The client was in good physical health with minor chronic physical conditions that were under medical control and did not significantly affect the client's activities. She had a significant hearing loss that was partially compensated by the use of hearing aids.

Social/Leisure Problems

The client could not identify any social/lesiure activities and was not observed to actively utilize her unstructured time on the unit. Therefore. the team decided to place her in the social/leisure activites module where crafts. table games. and other types of socialization are prompted and reinforced.

Skills Deficits Problems

Initial assessments indicated that Mrs. A. was deficient in several kinds of behaviors and skills. The MIBS behavior ratings showed her to be anxious. depressed. and socially withdrawn. Furthermore, she was lacking in work. social. and personal competences. Her general activity level was also very low. The CAPS showed that her general level of adjustment was at the inpatient rather than a community level of functioning. The STAIC confirmed that she was quite anxious. Her Life Satisfaction score was quite low. Within specific skills areas, her communication lacked effectiveness and appeared rather apathetic, primarily because she failed to use hand gestures and body movements appropriately. Within the area of daily living skills, she had good personal hygiene and intermediate level skills such as care of clothing and use of the telephone (ADL I and II). However, she was lacking in independent living skills, including budgeting, housekeeping, use of community resources, and meal preparation (ADL III). Her medication-taking skills were poor, and she expressed considerable anxiety about being able to learn about her medication and to learn to take it properly.

Based upon these assessments, the client was immediately entered into communications training and all available leisure activities. Although observation of her frequency of conversation found that participation was adequate, she was also scheduled to participate in the conversation group because this is an activity that is incompatible with depression and withdrawal. She was not entered into ADL III training or self-esteem training immediately because these groups were full. Neither did she begin medication training the first month because it was thought that her medication might be varied during this period.

Placement Problems

The client expressed great dissatisfaction with her current placement. The team decided to help her and her family to explore the possibilities of returning to independent or semiindependent living in her hometown of Georgia.

Month 1

Mental Health Problems

The client was entered into individual cognitive behavior therapy for depression. The individual therapy began with an interview and consisted of identifying the client's depressive cognitive behavior. The client's cognitions centered around beliefs that she was weak, dependent, and helpless without her husband, John. A few lines of typical therapeutic interaction follow:

C: You know Doctor I just can't go on without John.
T: John meant a lot to you.
C: John did everything for me; he was so good [*cries*].
T: You did things for John, too. Like cooking and cleaning, and washing clothes.
C: But that's what I was supposed to do.
T: So you can still do these things.
C: I can't. I just can't. I don't have the strength. Doctor, my husband would be so angry to see the fix that I'm in. It'd break his heart.
T: That means if he'd see you active and happy and doing things more, he'd be happy . . . not angry and broken hearted.
C: I guess so, but I can't do it any more.
T: You've always been a strong, independent woman. And your reward was seeing John's happiness. Maybe when you begin to feel so weak and helpless, you could at least remember the times when you were so strong and independent and you could also remember how happy John felt. Then you felt happy because John was happy.
C: I don't know.

This excerpt depicts the therapist correcting various cognitive distortions. This excerpt also demonstrates the process of rewarding one thought, "I'm strong," with another, "That would make John happy."

The first month of twice-weekly therapy sessions focused on the development of a relationship with the psychologist. The client was not accustomed to talking about problems in cognitive or "psychological" terms; therefore, the initial task was to shift the focus from physiological complaints ("I feel shaky and hot") to more psychological complaints ("I feel anxious and scared"). This task was accomplished by simply representing physical complaints in psychological terms. For example:

C: I'm just shaking so badly. I'm just so hot and shaky. Do you reckon I'd die?
T: You look pretty anxious about something. I wonder why you're so scared.

The client also engaged in various cognitive distortions common to depression (Beck *et al.*, 1979). These included arbitrary inferences made by drawing to a con-

BEST COPY AVAILABLE

clusion with no evidence. selective abstraction made by focusing on details of context. overgeneralizations made by drawing general conclusions based upon a single incident. and magnification or catastrophizing. For example:

"I'm no good." (arbitrary inference)
"The apartment is so small I can't stand it." (overgeneralization)
"I can't stand it anymore." (magnification)
"I'm useless without John." (selective abstraction)
"I can't cook, I can't clean, I can't do anything." (overgeneralization)

These distortions were corrected as they occurred. More realistic verbalizations were reinforced with approval by the therapist.

Maladaptive Behavior Problems

Approximately 15 instances of self-isolation and withdrawal behavior were noted (through BAF summaries) during the month. In addition to the formal observations, the hourly rounds indicated that the client spent a high percentage (85%) of her waking time engaged in solitary activities. Informal observations of the client further suggested that she was somewhat withdrawn and reclusive.

Thus, a treatment plan was developed to prompt the client to engage in prosocial activities when she was observed to be engaging in solitary activities. The client was reinforced with social praise from the staff.

Physical Health Problems

The client's hearing was evaluated by the unit's physician, and hearing aids were prescribed. In addition, she was started on a high dosage of tetracyclic antidepressants to actively combat the depression.

Skill-Deficit Problems

Mrs. A. showed progress on several of her assessments completed at the end of the first month. On the MIBS, the Anxious-Depression score had dropped dramatically to a normal level. Withdrawal improved moderately but remained an obvious problem. The competence scores showed very little or no improvement. The CAP score improved considerably to a level intermediate between the inpatient and discharge level. The STAIC score decreased somewhat, showing a moderate improvement in anxiety.

In the training activities, communication improved to a point that Mrs. A. was scoring at an acceptable level on all items. Life-satisfaction, however, improved only slightly. (She had not yet entered self-esteem training.) She was reassessed on ADL III at this time, and she scored lower than on the previous assessment. Training in this area had also not yet begun.

In the other structural activities, she attended and participated minimally. She began ADL III and medication training at the beginning of the second month.

Placement Problems

The clinical psychologist met with the client and her son and daughter-in-law to explain the program, to answer the concerns of all of them, and to establish and develop the necessary information on which to base future discussions of placement.

Month 2

During the second month of treatment, the client showed continued improvement. The greatest improvement was with respect to depression.

Mental Health Problems

The client continued in twice-daily individual therapy sessions. During the second month of individual therapy she began to verbalize several new concerns, including her feelings of anger toward the husband (for dying and leaving her alone) and anger at the son and daughter-in-law for "insisting" that she move from Georgia to Florida. The client also repeatedly asked: "Do you think I'll ever be well again?" An excerpt from a typical session follows:

C: Do you think I'm losing my mind?

T: What do you think?

C: Sometimes I wonder, Doctor. I'm so angry about being here in Florida. If I could just get back to Georgia.

T: What's stopping you from heading back to Georgia?

C: Well, I think Bobby and Marion [*son and daughter-in-law*] think I'll get upset again. Maybe I would. I don't know. This is an awful fix I'm in.

T: When you say those things to yourself like "How awful things are" you help to keep yourself unhappy.

C: I know.

T. So, getting back to what you said, do you think that if you get to feeling better Bobby and Marion might be more willing to get you back to Georgia?

C: I don't know. I guess they would help me.

T: Then that's all the more reason to get better, isn't it? By getting better you can think to yourself, "This is helping to get me home to Georgia."

In this excerpt, a useful reinforcing thought, *helping to get me home to Georgia*, and its usage is illustrated. Also, the modification of a maximization cognitive distortion ("an awful fix") is demonstrated.

At various times during a session, the client might venture into the topic of anger and/or sadness experienced over the husband's death. During these ventures the therapist shifted into a more client-centered/reflective mode. It was thought that by neither encouraging nor discouraging these expressions, the client was afforded the opportunity to desensitize herself to the hurtful reality of the husband's death.

Maladaptive Behavior Problems

The client began to interact more with the staff and clients during the second month. However, there were frequent reports of complaints, insults to other clients, swearing, and refusing to participate in several activities. The complaining and refusing were placed on extinction by instructing the staff to ignore them. The

BEST COPY AVAILABLE

insults were dealt with by prompting the client to apologize as a form of restitution. Otherwise, the initial plan remained in effect.

Physical Health Problems

The client continued on a high dose of antidepressants. She decided to defer the purchase of new hearing aids.

Skill-Deficit Problems

By the end of the second month, the MIBS scores on the competency areas and/or activity level were high. The anxious-depression score remained quite low, and the withdrawal score improved enough to indicate that this problem had been practically eliminated. The CAPS scored improved slightly, and the score on the anxiety scale fell to a very low level. Life-satisfaction continued a slight decline; however, she had not yet begun self-esteem training, which addresses this problem. She continued to perform well in communications and reasonably well in leisure activities and conversation. ADL III training was still not begun. In spite of her anxieties about her medications, she learned very quickly their names, dosages, and reasons for application. She was now ready to start getting out her own medicines from the pharmacy cart but expressed much anxiety over being able to do this.

Placement Problems

The client and family met once during the month to discuss treatment progress and to discuss a return to Georgia. The client and family agreed to pursue a return to Georgia as long as the client showed improvement. Also, the concept of a gradual return to the Florida apartment as an "interim" placement was introduced.

Month 3

The third month was a "turning point" in treatment. It also marked the halfway point for the client in the program. She began to show noticeable improvement on various indexes.

Mental Health Problems

The client continued in twice-weekly individual psychotherapy sessions. She made the necessary cognitive changes for more adaptive functioning. Specifically, she showed a reduction in the number of cognitive distortions associated with depression.

Behavioral chaining techniques were utilized to facilitate the adoption of another reinforcing and adaptive cognition. Its development is depicted in the following excerpt:

C: You know, Doctor, I just can't wait to get back to Georgia. That's what I've needed all along.

T: I can sense your excitement. But I'm not sure that you'll be able to leave here and go straight to Georgia.

C: Oh. I've got to. I just couldn't stand going back to that closed in apartment [*in Florida*].

T: It might be unpleasant but I think you could "stand" it: especially if it were the final stepping stone to Georgia.

C: It would be hard to leave here and go straight to Georgia I guess. Somebody would have to pack up my things, at the very least.

T: So you see that returning to your apartment here in Florida is the last link in a struggle you've worked so hard to overcome. When you get to your apartment you can think. "I'm almost there."

Thus, the groundwork was in place upon which to build two additional ideas. First, the client was encouraged to think of a gradual return to the Florida apartment and, second, she was encouraged to think of returning to Georgia for a "trial visit." The "trial visits" to both the Florida apartment and her Georgia home allowed for flexibility in the treatment plan and afforded the client a chance to desensitize herself to the anxiety/depression cognitions provoked by the thought of returning to the Florida apartment.

Incidentally, the client's verbalizations about John decreased during the month. Her appetite, sleeping pattern, and activity level all showed improvement. No maladaptive behaviors were observed.

Skill-Deficit Problems

All clinical scores on the MIBS remained low, with the exception of the remaining small elevation on withdrawal. The CAPS again continued to show steady improvement to the point that this score reached the level acceptable for discharge. On the self-report instruments, there was an indication of a small increase on anxiety, but life satisfaction improved markedly for the first time.

In the training modules, she maintained all the gains previously attained. In addition, she improved on housekeeping in ADL III and was now taking her medications very comfortably.

Placement Problems

The client's son and daughter-in-law met three times with her and the psychologist to discuss the treatment plan. Initially, the children were reluctant to help their mother consider a return to Georgia. Nonetheless, they understood the value of this and agree that if she were able to overcome helplessness and depression there would be no reason why she could not return to Georgia. The client's children were also informed about operant conditioning processes. They learned that by rushing to their mother's aid at her every call perpetuated the very problem they were attempting to extinguish. Additionally, the children were instructed to vigorously dispute cognitive distortions when they heard them made by the client. Thus, the children began to become important therapeutic allies rather than therapeutic liabilities.

Month 4

The client continued to show programmatic improvement during Month 4 of treatment. She began to prepare for discharge during this month, and this increased stress appeared to influence her anxious/depressive verbalizations.

Mental Health Problems

There were no increases observed in the client's cognitive distortions. However, she reported slight increases in feelings of depression, sleep disturbances, and appetite disturbances. The client also reported anxiety about going home on weekend passes in preparation for discharge. She reported, however, that most of her "sad" thoughts and feelings occurred at mealtime and at bedtime when she would think of John. The client was instructed that it was permissible to think of John at any time except mealtimes and bedtimes to disrupt the chain of stimuli that elicited thoughts about him. She began to actively search out other clients to share her mealtimes and made modest changes in her bedtime routines. The client was instructed to change her cognitions about John by substituting cognitions centered around plans for the next day.

No significant maladaptive behaviors were noted during the month except for one report of the client's crying and complaining of being depressed. Her antidepressant medication was increased slightly to help combat the depression while discharge planning proceeded.

Skill-Deficit Problems

Scores on the MIBS competence scales remained at a very high level, whereas the scores relating to problem behaviors remained low. However, there still was an indication of some small problem with withdrawal. The CAPS score continued to improve. The anxiety score increased some, but remained moderate. Life-satisfaction continued to improve. Communications scores and participation in structured activities remained good. Scores on housekeeping continued to improve, but no improvement was noted in the other advanced ADL areas. She continued taking her medication confidently and without errors.

Placement Problems

A fortunate coincidence occurred during the initial weekend passes taken by the client, in that her children took a vacation away from the area. Despite bitter protests by the client that she would "die" if left alone in her apartment without the children nearby, weekend passes were encouraged. The first weekend pass was for 4 hours, the next was for 8 hours, the third was for approximately 12 hours including an overnight stay, and so on until the client was able to stay in her apartment for the entire weekend. During the first three weekend passes her children were out of town on vacation and thus were unavailable to reinforce her dependency. As predicted, she managed each of these passes without incident and seemed to be very pleased and surprised with her ability to tolerate the return to the apartment. During the fourth weekend visit, the client again complained bitterly, insisting that she could not survive the weekend. Not coincidentally, this was the first weekend pass issued since the return of the children. Thus, arrangements were made to work actively with the son and daughter-in-law during the last month of treatment.

Month 5

The client was discharged at the end of the fifth month of treatment. She had spent nearly 6 months in the hospital completing the various assessments and treatment.

Mental Health Problems

The individual sessions during this month consisted of three therapeutic tasks. First, the client's weekend passes were evaluated, and the next weekend pass was planned. Second, the client engaged in termination from the therapeutic relationship. As is typical in termination, the client began to express anger toward the therapist and sadness at the thought of leaving. She was very reluctant to say goodbye to the other clients. Nonetheless, she was prompted to engage in telling the clients goodbye and to share with them her accomplishments while in treatment. Third, the client was prepared to continue her treatment on an outpatient basis.

Skill-Deficit Problems

The MIBS Problem Behavior scores all remained low at this time, although the small elevation on withdrawal remained. The competency scores remained high and anxiety remained low. The CAPS score also remained high. Life-satisfaction remained at the level of the previous month, which was much improved. In ADL, she improved on community resources, meals, and housekeeping. She did not improve on budgeting, principally because she insisted that her son take care of several tasks and therefore she refused to learn.

Placement Problems

The client began to verbalize her doubt that a return to Georgia was in her best interest. She seemed to realistically wonder whether returning to Georgia would only bring back painful memories. She did, however, continue to plan a visit to Georgia. Her children met with the psychologist to review the client's treatment. It was reiterated to them that they should be extremely cautious about reinforcing the client's dependency. They were offered strategies to help reinforce the client's independence. For example, the children were to put all "catastrophic" phone calls ("I'm dying") on extinction by saying, "You should call an ambulance," and by hanging up. Pleasant conversations were to continue until complaining occurred, at which point the conversation was to be terminated. Additionally, visits to the client were to occur anytime she engaged in a new activity (e.g., making a new friend, going to an apartment residents' meeting, etc.). Otherwise, visits would occur at the rate of once every two weeks. Finally, the client was permitted to visit the children at any time if she drove herself. Prior to admission the client was very reluctant to resume driving her automobile and to learn the roadways of Florida. Thus, she was encouraged to resume this activity.

Although systematic and objective follow-up assessment is not a regular part of this program, informal follow-up data through telephone interviews with the client and the son and daughter-in-law were available.

Follow-Up

Six Weeks

The client decided to stop taking antidepressant medication because she was "doing too well." The children were not aware of this fact. The client had made an extremely good adjustment for approximately 2 weeks, then decided that she could stop her medication. She reported that she began to withdraw progressively during the next 3 weeks. True to form, the children began to respond more and more to the client's complaints and initiated a request to the psychologist for help. The psychologist recommended that the client visit a psychiatrist for refilling the antidepressant medication prescription. Also, the client was encouraged to seek out regular psychotherapeutic interventions. The family was reminded of the adverse effects of reinforcing the client's dependency.

Six Months

The client had maintained her community adjustment. She had not begun individual therapy but continued to take antidepressant medication. Although she complained that nothing had changed, she had made many new friends at the apartment complex and was involved in many activities there. She drove her automobile sporadically, mostly to the grocery store and to her children's residence. The relationship between the client and her children had stablilized somewhere between the extreme dependency exhibited prior to hospitalization and complete independence she had exhibited prior to her husband's death. The client had not yet initiated a visit to Georgia.

The preceding case illustrates the assessment and treatment of a common presenting problem in the elderly client (i.e., depression). The following case presentation illustrates another common presenting problem: dementia. The treatment program illustrated next relies heavily upon the structured modular assessments and treatments. No cognitive therapy was required; thus therapist–client dialogue is noticeably absent. To avoid redundancy, this case will not be presented on a month-by-month basis, but rather specific problem areas will be addressed in summary fashion.

The Case of Mrs. C.

Mrs. C. was a 69-year-old white widowed female referred to the program with a diagnosis of primary degenerative dementia, senile onset with delirium. The client also had Parkinson's disease. The onset of the client's problem was gradual and apparently accelerated subsequent to the death of her husband of 48 years. Her first psychiatric hospitalization occurred 1 month prior to admission to our program. Previous to the psychiatric hospitalization the client became very anxious, experienced memory problems, and feared that people were trying to break into her home. She was described as being confused and as having auditory and visual hallucinations.

Initial Assessment

Mrs. C. had a very supportive family and was part of a European ethnic community; thus, her social support system was excellent. The client's Parkinson's disease was under medical control, and she was in good physical health otherwise.

Her presenting problem of dementia required careful assessment to rule out depression, because the two diagnoses are often confused in elderly clients (Libow, 1977). Because nearly all elderly patients will have experienced significant losses of one sort or another, the potential for depression is quite high. Mrs. C. was evaluated by the clinical psychologist via a clinical interview. The interview and assessment data suggested a mild degree of depression due to the loss of the spouse, but the primary problems appeared to be due to dementia and the resulting loss of previously acquired behavioral skills.

Thus, the treatment team decided to focus the client's treatment on the reacquisition of memory and ADL skills, and the development of the client's communication skills and self-esteem skills. The total length of treatment was 6 months.

Memory Training

Spatial Orientation

The client was not found to be deficient in spatial orientation upon initial assessment. She continued to show no spatial orientation deficiencies throughout the 6 months of treatment.

Personal Information

The client was initially found to be deficient in personal information skills, but within 3 months of training her performance was at maximum levels and was maintained until discharge. Thus, she was able to reacquire and maintain basis memory skills.

ADL (Independent Living Skills)

Budgeting

The client maintained her budgetary skills at a moderate level throughout the 6 months of training. She was not judged to be capable of independent budgeting at the time of discharge, and thus the team recommended that she seek assistance from family members when writing checks, paying bills, and balancing her checkbook.

Community Resources

Initially the client was extremely deficient in her ability to utilize community resources. By the end of training she had improved considerably but was not judged to be capable of independent procurement of community resources.

Meals

Initially, the client was assessed as having good meal selection and preparation skills. She maintained these skills throughout training.

Housekeeping

Initially, the client was assessed as having moderate housekeeping skills. However, she gradually improved in this area throughout training. At the time of discharge, she was judged to have adequate independent housekeeping skills.

Summary of ADL Training

The client had no deficiences in personal grooming skills, use of telephone, and simple housekeeping and meal selection skills (ADL I and II). She did, however, evince deficiencies in more complex ADL skills. At the time of discharge, the client was not judged to be capable of completely independent functioning. She had difficulties in the areas of budgeting and obtaining community resources and was in need of assistance in these areas.

Communication Training

The focus of communication training was on all of the six discrete skills: content, loudness, feeling quality, hand gestures, facial expressions, and body position. The client was trained to communicate both pleasure and displeasure. Initially, she was assessed as having relative good pleasure communication skills and relatively poor displeasure communication skills.

After the third month of training the client was at, or near, the maximum levels in all skill areas of training in both the pleasure and displeasure roleplayed assessments. She was able to maintain these communication skills throughout the remaining 3 months of her treatment.

Self-Esteem Training

The client entered into self-esteem training during the final 3 months of her treatment. She was assessed with the LSI and with respect to the actual number of positive self-statements that she made during training sessions. During training, the client's life satisfaction scores increased from 10 to 17, which represented a significant increase in overall life satisfaction. Similarly, her positive verbalizations increased from an average of 5 per session at the beginning of training to as high as 13 per session near the end of training. This, too, represented a significant change in the client's behavior with respect to her self-esteem.

Other Areas of Training

In addition to the training areas discussed previously, the client's use of her unstructured time and her abilities to know the names and dosages of her medications were monitored. Throughout the course of treatment, use of her unstructured time was judged to be outstanding. She engaged in a wide variety of activities, including appropriate solitary (sewing, art work, etc.) and prosocial (conversation, table-game playing, etc.) activities. By the time of discharge, the client's knowledge of her medications was also judged to be excellent and her ability to take her medicines correctly was rarely, if ever, a problem.

Summary of the Case of Mrs. C.

The client entered into the program after a long and gradual deterioration of her independent living skills and increasing confusion, disorientation, and delirium. Although she had defined anxiety as a major problem, no significant evidence could be found for either anxiety or depression. The client's STAIC and BDI scores remained within normal limits throughout her treatment. In addition, MIBS subscales indicated no problems with withdrawal, anxious depression, or any other maladaptive behaviors. The MIBS competence subscales showed gradual improvement over the course of treatment.

The treatment for this client focused primarily upon the reacquisition of previous skills and abilities. The retraining accomplished over the 6 months of treatment resulted in the client's being able to return to independent community living while requiring occasional assistance. Her assessment scores reflected the results of the retraining.

Approximately 1 month before discharge, the client decided to move to the New England area to live with her son and daughter-in-law. They were very pleased to have her live with them. This arrangement appeared to be an ideal placement for the client because she would be in a supportive environment but could function relatively independently.

Follow-Up

A 3-month telephone follow-up revealed that the client continued to maintain the skills she had reacquired. She and the daughter-in-law were interviewed, and both gave convergent descriptions of the client's behavior. At follow-up the client reported no significant memory problems and was engaging in daily exercise doing regular housekeeping activities, caring for her granddaughter, socializing with neighbors, taking her medications, and attending follow-up mental and physical health appointments. No recurrence of the confusion or delirium was reported.

Summary

A treatment program for the hospitalized elderly has been described in some detail. Although an outpatient therapist may not be able to provide the type of comprehensive treatment described herein, it is hoped that the outpatient therapist will have increased awareness of all the facets involved in the treatment of the elderly. Furthermore, the assessment and decision process has been described in some detail to illustrate how behaviorally based clinical psychology can operate in the "real world" of treatment. As described, a thorough objective assessment is essential for treatment selection and evaluation. Finally, the actual application of treatment has been described through two case illustrations to allow the clinician to see how treatment decisions are carried through and applied to the client and are then systematically and objectively evaluated.

References

Baltes, M. M., Burgess, R. L., & Stewart, R. B. (1980). Independence and dependence in nursing home residents: An operant ecological study. *International Journal of Behavioral Development, 3*, 489–500.

Beck, A. T. (1979). *Cognitive therapy and emotional disorders.* New York: New American Library.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. *Cognitive therapy of depression.* New York: Guilford Press, 1979.

Carroll, K. (Ed.). (1978). *Human development in aging: Compensating for sensory loss.* Minneapolis: The Ebenezer Center for Aging and Human Development.

Gordon, D. M. (1974). Eye problems of the aged. In A. B. Chinn (Ed.), *Working with older people* (Vol. IV). *Clinical aspects of aging.* Washington DC: U.S. Department of Health and Human Services.

Hogarty, G. E., & Ulrich, R. (1972). The discharge readiness inventory. *Archives of General Psychiatry, 26*, 414–426.

Kalish, R. A. (1975). *Late adulthood: Perspectives in human development.* Monterey, CA: Brooks/Cole.

Kalish, R. A. (1977). *The later years.* Belmont, CA: Wadsworth.

Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. (1963). Studies of illness in the aged. The index of ADL, a standardized measure of biological and psychosocial function. *Journal of the American Medical Association, 185*, 914–919.

Kuhlen, R. G. (1959). Aging and life adjustment. In J. E. Birren (Ed.), *Handbook of aging and the individual.* Chicago: University of Chicago Press.

Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. *Journal of Gerontology, 33*, 109–129.

Libow, L. S. (1977). Senile dementia and "pseudo-senility": Clinical diagnosis. M. C. Eisdorfer & R. O. Friedel (Eds.), *Cognitive and emotional disturbances in the elderly.* Chicago: Year Book Medical Publishers.

Maurer, J. F. (1976). Auditory impairment and aging. In B. Jacobs (Ed.), *Working with the impaired elderly.* Washington DC: The National Council on Aging.

Meichenbaum, D. (1977). *Cognitive behavior modification: An integrative approach.* New York: Plenum Press.

Missouri Psychiatric Institute. (n.d.). *Missouri Inpatient Behavior Scale (MIBS).* St. Louis: Author.

Neugarten, B., Havighurst, R., & Tobin, S. (1961). The measurement of life satisfaction. *Journal of Gerontology, 16*, 134–143.

Patterson, R. L., & Jackson, G. M. (1980). Behavioral approaches to gerontology. In L. Michelson, M. Hersen, & S. M. Turner (Eds.), *Future perspectives in behavior therapy* (pp. 206–241). New York: Plenum Press.

Patterson, R. L., O'Sullivan, M. J., & Spielberger, C. D. (1980). Measurement of state and trait anxiety in elderly mental health clients. *Journal of Behavioral Assessment, 2*, 89–97.

Patterson, R. L., Dupree, L. W., Eberly, D. A., Jackson, G. W., O'Sullivan, M. J., Penner, L. A., & Dee-Kelley, C. (1982). *Overcoming deficits of aging: A behavioral approach.* New York: Plenum Press.

Patterson, R. L., Penner, L. A., Eberly, D. A., & Harrell, T. L. (1983). Behavioral assessments of intellectual competence, communication skills and personal hygiene skills of elderly persons. *Behavioral Assessment, 5*, 207–218.

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficits in elderly patients. *Journal of the American Geriatric Society, 23*, 433–436.

Pfeiffer, E., Johnson, T. M., & Chiofolo, R. C. (1981). Functional assessment of elderly subjects in four service settings. *Journal of the American Geriatric Society, 29*, 433–437.

Sletten, I. W., & Ulett, G. A. (1972). The present status of automation in a state psychiatric system. *Psychiatric Annals, 2*, 77–80.

Spielberger, C. D., Edwards, C. D., Lushene, R. E., Montouri, J., & Platzek, D. (1973). *STAIC: Preliminary Manual for the State-Trait Anxiety Inventory for Children.* Palo Alto, CA: Consulting Psychologists Press.

Yesavage, J. A., Westphal, J., & Rush, L. (1981). Senile dementia: Combined pharmacologic and psychologic treatment. *Journal of the American Geriatric Society, 24*, 164–170.

Begin with a brief review of sensory losses from the manual. Define "communication" as the person-to-person exchange of information through verbal and nonverbal means. Ask class to give some examples of verbal communication (words, gasps, screams, laughter, etc.), and nonverbal communications (crossed arms, turning away, smiling, nodding, stance, and manner of dress).

Communication is accomplished when one person sends a coded message and another person is able to interpret the code correctly . Conflicts result when messages are improperly decoded.

Points to emphasize:

Communication, verbal and nonverbal, includes three essential aspects:

1. The transmission of information
2. The meaning of the transmission
3. The behavioral effects of the transmission

The transmission of information is the sending and receiving of messages, units of information. Via the feedback process, every person is affected by the behavior of everyone else involved.

Speech is the most commonly used mode of deliberate communication. It often falls short of its task. Speech is vulnerable to defects, disease, sensory impairments, and educational differences.

Verbal communication is always accompanied by nonverbal communication. Nonverbal communication may do the following:

1. Complement verbal communication
2. Contradict verbal behavior
3. Emphasize an emotional tone or mood
4. Control the environment
5. Be the communication of choice

The physical environment affects the communication process. Environment can include external factors such as the setting, proximity of those communicating, noise levels, and internal factors (i.e., perception of temperature, comfort, and physical distress).

Set aside some time for the group to practice the basic listening skills outlined in the manual.

It should be stressed that poor interpersonal skills cause more barriers to effective communication than physical disabilities. Communication becomes dysfunctional when it is colored by personal bias, belief in stereotypes, and ambivalent feelings.

Ambivalence is the simultaneous existence of opposing feelings about something or someone. A caregiver can experience concern for a client who is old and ill. Discomfort can also be experienced in the client's presence because his or her age and illness may frighten the caregiver. This caregiver's communication with and behavior toward the older person could easily vacillate between overprotectiveness and avoidance.

Too often the elderly, especially the frail elderly, are spoken to as though they were children. Discuss the following scene with the members of the class.

A case for discussion----

The inhalation therapist was very gentle with the old woman. He was reluctant to wake her from restful sleep in order to treat her, and he came back several times to see if she had awakened by herself. Finally, he approached her quietly, put his hand on her cheek and called her name softly. She woke, smiling, recognized him immediately and asked if it was time for her "breathing".

"That's right, Molly," he answered, "You were fast asleep. weren't you? Naughty girl, you should be up and waiting for me!"

Mrs. Abrahams' smile was a little smaller. "I'm sorry," she answered. "I'm afraid I really don't know your schedule."

"Now, now, let's not get too nosy. Next thing you know, you'll be ducking out when you know I'm coming".

"Why would I do that?" Mrs. Abrahams murmured. She was no longer smiling.

"Just the natural desire to play hookey...isn't that what kids do?"

"Kids?"

"Oh, come along now, don't pout. Let me see you smile! I can't do my work unless you smile!"

Mrs. Abrahams said nothing, but submitted patiently to the therapy. Later, she heard the therapist talking to someone in the corridor outside the door. "I just love old people, don't you? They're so cute (murmur in response). Oh they're just like small children. I can usually coax them around to cooperate with me."

"The point is, they know I love them. I really do. I can sense that, so we always have a good relationship."

What is the connection between love and denigration? How can it be so easy to seesaw between honest feelings and expressions of affection at one moment and insulting, ego-destroying behaviors the next?

In this case, part of the problem arises from the mistaken premise that old persons are like children.

Such a caregiver would feel perfectly comfortable responding to an old man in the same way she would respond to a small child: "Eat your spinach or there'll be no T.V. tonight." Think of the metacommunication--a child needs to learn that he needs to act and live independently--what about an adult?

(a) he cannot rationally utilize factual data (food is a vital factor in his recovery).

(b) anyone has the right to deprive him of T.V. without his compliance.

(c) anyone has the right to force his compliance with a threat.

There seems to be much contempt built into the image portrayed of such an adult.

The following material was developed by Arthur P. Bachner, Chairperson, Department of Communication, U.S.F., and is being used with his permission.

THE COMMUNICATIONAL PERSPECTIVE

What are some features of communication?

1. One cannot not communicate.
2. There are numerous simultaneous messages being exchanged.
3. Individuals may be conscious or unconscious of their behavior.
4. Messages may be intentionally or unintentionally sent.
5. Communication behavior adheres to cultural rules and expectations.
6. Communication has numerous social influences.
7. The meaning of behavior is context-dependent.
8. Most behavior is arbitrary, conventionalized, and learned.
9. Social behavior is subject to change, historically or individually.
10. Communication is the "stuff" which creates reality: "If men define situations as real, they are real in their consequences."

COMMUNICATION BARRIERS

Ineffective communication is often the result of many factors. Continual "self-tuning" is necessary to ensure satisfaction for you and others. Don't assume. Check your inferences and assumptions to minimize the extent to which any of the following disrupt your communication.

1. Sender lacks knowledge of the subject or is inadequately prepared.
2. Sender does not believe in the message or the policy behind it.
3. Sender unintentionally fails to say what she/he means.
4. Sender and/or receiver are temporarily preoccupied.
5. Sender and receiver have different vocabularies.
6. Cultural differences exist between the communicators.
7. Sender and receiver have professional differences.
8. Communicators have status differences.
9. Communicators have age difference.
10. One of the communicators is a "yes man" to the other.
11. Sender and receiver have different assumptions.
12. One of the communicators has a negative/hostile attitude toward the other.
13. Language is inadequate to express difficult concepts, relationships, or situations.
14. Same words have different meanings.
15. Receiver lacks knowledge of the subject or is inadequately prepared.
16. Receiver is not interested in the subject.
17. Lack of time pressures the interaction.
18. Outside interferences or distractions are present.
19. Feedback system is inadequate.
20. Special problems:
    a) Giving advice
    b) Moralizing and preaching
    c) Analyzing and diagnosing
    d) Judging and criticizing

COMMUNICATING WITH THE ELDERLY

KNOW YOUR AUDIENCE

This section deals with the relationship you have with your clients from a communication perspective. One of the first lessons that a communication perspective tells you is that relationships involve at least two people, and you will be able to get what you want. In other words, know to whom you are talking. With this in mind, I have prepared a brief outline of the aging process. You may already be fully aware of this process either in your own life or because you have observed the activities of the nursing home residents. What you may not be aware of is that the stages in this process affect the way in which people communicate. Therefore, as you read through the list, think about how the communication of the elderly person would be influenced by these physical, biological, perceptual, and mental changes.

I. Biological and Physical Changes

  A. Appearance

    1. Skin is more susceptible to bruises and blemishes.
    2. Posture may change as spinal disks compress.
    3. Hair loss increases.

  B. Muscles and Heart

    Decreasing circulation and blood supply with age

  C. Lungs, Kidneys, and Intestines

    Changes in these organs may require the assistance of others for basic human functions.

D. Sleep

The older you become, the more likely you are to lose the ability to engage in the deepest and most relaxing states of sleep.

II. Sensual and Perceptual Changes

A. Vision

Elderly people usually experience changes in color perception and sensitivity to brightness.

B. Hearing

It is more difficult for an older person to hear high-pitched and low intensity sounds.

III. Mental Changes

A. Learning

1. Because of the physical and perceptual changes listed above, the learning process takes longer and must be carefully paced.
2. Learning usually requires more time and less distraction.

B. Memory

1. Four types
    a. Short-term (recall after 5 to 30 seconds)
    b. Recent (1 hour to a few days)
    c. Remote (past events that have been frequently recalled)
    d. Old (past events that have generally not been thought of)

2. With age, there is greater loss in short-term and recent memory, than in remote or old.

3. Retention of things heard is slightly better than of things seen.

C. Problem-solving and Creativity

1. There is every indication that the elderly are able to offer totally new and different ideas.

2. Most studies of the elderly indicate that the originality of ideas increases as we get older.

3. Emphasis is placed on accuracy rather than speed.

D. Motivation

Institutionalized persons may be operating below their potential because of the low expectations held by families and institutional personnel.

COMMUNICATING WITH THE ELDERLY

TIPS AND TACTICS

1. Recognize the other person's communicative abilities.
2. Face the other person when talking to him/her.
3. Windows or bright lights should be behind the other person so that he/she is not facing a glare.
4. Gain the other person's attention before attempting to communicate with him/her. Touching him/her on a non-threatening body area (e.g. the shoulder or hands) may indicate warmth and acceptance. Encourage the other person to look at you; preface your remarks with an address or greeting.
5. Loudness may distort the sounds you say (even with the hard-of-hearing or deaf person). Speak slowly and distinctly without unnecessary volume.
6. When speaking slowly, take care not to exaggerate the sounds. Over-emphasis may distort the person's cues for lip-reading.
7. While talking, avoid distractions such as covering your mouth with your hand or chewing gum.
8. Speak in a friendly manner, but do not treat the other person as though he/she were a child.
9. Ask simple and direct questions, one at a time. Allow sufficient time for the other person to process the question. Repeat or rephrase the question if necessary.
10. Keep instructions short and simple. Accompany them with gestures.
11. Maintain eye contact while talking.

12. If the other person seems to misunderstand you, repeat or rephrase your message. If he/she still has difficulty, a communication board or written message may help.
13. Take care not to talk for the other person unless absolutely necessary.
14. Listen to the other person. Allow him/her to finish his/her message. If the message is unintelligible and you are rushed, explain you will return later when you have time.

BLANK PAGE

COMMUNICATION

Name ______________________________ **Date:** ________________

CIRCLE THE CORRECT ANSWER.

1. Touching may be an effective way to establish contact with a client, and the elderly generally react to touching __________ than young adult clients.

    a. less favorably
    b. no differently
    c. more favorably

2. In communicating with the elderly, it is of utmost importance to recognize feelings about aging and death that exist:

    a. for you
    b. for the elderly
    c. for society

3. The listening skill which is central to establishing good communication with an elderly client is:

    a. paraphrasing
    b. clarifying
    c. attending

4. Verbal communication is ____________ accompanied by nonverbal communication.

    a. never
    b. sometimes
    c. always

5. An older person may be able to hear speech best if:

    a. you speak in a lower tone
    b. you shout at them
    c. the surrounding noise forces them to concentrate on you

6. Fear, shame, and anxiety

    a. can interfere with communication
    b. have nothing to do with communication
    c. can be avoided by paraphrasing

7. A communication skill that encourages responding in an open manner is called:

   a. reflection
   b. clarifying
   c. leading

8. A skill that may be useful in reducing vagueness and confusion in a message is:

   a. focusing
   b. reflection of content
   c. attending

9. ______________ is a skill that involves using questions in order to "check out" the accuracy of a statement.

   a. Paraphrasing
   b. Clarifying
   c. Focusing

10. ______________ can enable the listener to indicate an understanding of the older person's experiences.
   a. Reflecting skills
   b. Attending skills
   c. Leading skills.

Communication

1. c
2. a
3. c
4. c
5. a
6. a
7. c
8. a
9. b
10. a

BLANK PAGE

The Psychosocial Evaluation of the Elderly Patient

Eric Pfeiffer, M.D.

University of South Florida

Successful treatment of elderly patients with psychiatric disorders depends to a major extent on the adequacy of the initial evaluation of psychological and social functioning. While the *diagnosis* may be based largely on the presence of specific *psychological symptoms*, the *prognosis* will depend heavily on the *social context* in which those psychological symptoms exist. For it is social factors which will affect, favorably or unfavorably, the degree of success of correctly chosen treatment modalities.

In keeping with a life-cycle approach to the psychiatry of aging, this chapter will focus in turn on (a) communicating with the elderly; (b) evaluation of present psychological functioning; (c) evaluation of previous psychological functioning; (d) evaluation of present social functioning; (e) evaluation of past social functioning. This approach is predicated on the assumption that there is a differential significance to present psychosocial malfunctioning where it occurs in persons with good as opposed to poor psychosocial functioning in the past. The chapter will also address (f) issues related to the nature of informal social support systems in the community; and (g) briefly describe a comprehensive multidimensional functional assessment methodology.

COMMUNICATING WITH THE ELDERLY

Factors Influencing Communication with the Elderly

In every human interaction, each participant makes a contribution that will influence the outcome. Both the patient and the physician must be considered as individuals before interaction can be understood properly. Factors influencing each may be assets or barriers to effective communication.

Patient Factors

Anxiety. Many elderly individuals may function continually at a high level of anxiety. Thus, the increased stress of a new situation may lead to intense arousal, impairing the elderly person's ability to communicate effectively. Every physician realizes that a visit to the doctor is often a stressful experience. Fear, shame, anxiety, and a host of other feelings may play an important role in the communication process in the physician's office.

Sensory Deprivation.[3] Hearing loss is a widespread problem among the elderly. It affects men more than women and occurs in some 30% of all older people. Hearing loss is potentially the most difficult sensory loss for the elderly patient. Although 80% of the elderly have fair to adequate vision, some visual problems may occur. For example, poor orientation, a decreasing ability to read, and an occasional frightening visual impression may complicate communication in the physician's office.

Cautiousness. Older people tend to make few errors of commission but are likely to make errors of omission.[3] When the physician takes a history, he or she must be aware that older people may omit important aspects of their illnesses. Older people also take longer to respond to inquiries. The physician who rushes through the history-taking may overlook valuable information.

Unrealistic Views of the Physician. The elderly patient may develop an unrealistic perception of the physician based on previous experiences (the process that psychiatrists call transference). The elderly person is likely to view the physician as a parent (leading to a marked dependence on the patient's part), or as a child (leading to instruction-giving, or inquiries about the physician's health and behavior). A positive transference can be of benefit in the management of the patient if handled properly. In fact, this country's malpractice crisis probably results more from poor communication between physicians and patients than from incompetent medical care.

Persistent Themes. The elderly patient may concentrate on particular themes in communicating with the physician. The more common themes include:

Somatic concern. Patients may spend much time complaining of ailments or recounting detailed histories of bodily functions. At a time when friends and loved ones have died and sensory input is decreased, the body, in many ways, keeps the patient company. It is therefore quite usual for the elderly patient to be somatically oriented.

Loss reactions. The elderly patient may spend considerable time discussing the many losses experienced in late life. These include loss of friends and loved ones, loss of physical functioning, loss of employment and previous activities, and loss of self-esteem.

Life review. There is a tendency in the elderly to reflect and reminisce. This is a normal process brought about by disillusion and the realization that death is approaching.

Fear of losing control. Many elderly patients agonize over the loss of physical and mental functions, including physical strength, bowel and bladder control, motor functions, and, especially, the ability to regulate one's thoughts and emotions. One of the greatest fears of late life is the fear of "going crazy."

Death. The elderly are not, as a rule, obsessed with approaching death, but it nevertheless is a frequent topic of conversation. The major fear is of being alone at the end of life. The physician must remember the importance of continued relationships for the elderly person.

Physician Factors

Attitudes Toward the Elderly. It is quite common to find fears of aging and death among members of our youth-oriented society. The recognition of such fears, and of the physician's personal feelings about these issues, is of utmost importance in establishing effective communication with the elderly.

Lack of Understanding. The physician must attempt to separate myths about aging from reality. For example, the labeling and stereotyping of the elderly may be a significant barrier to communication. The elderly are especially sensitive to being labeled "senile," "mentally ill," or "hypochondriac." The physician should try to empathize with the elderly patient. Putting yourself in the other person's shoes is an ability not easily taught by textbooks and can only be learned through personal experiences.

Techniques of Effective Communication

Approach the elderly patient with respect. The physician should knock before entering the examining room and try to approach the patient from the front. Greet the patient by surname (Mr. Smith, Mrs. Ross) rather than by given name (Johnny, Mary), unless he or she wishes to be addressed by a given name.

Position yourself near the older patient. The physician should place himself or herself near enough to be able to reach out and touch the patient if desired. The most comfortable arrangement of chairs for both parties is at a 45-degree angle to each other. If possible, chairs should be of the same height and the physician should not stand or walk during the interview.

Speak clearly and slowly. The elderly patient may have a hearing problem or may not understand a physician's accent. Clarity of speech and the use of simple sentences is most effective in communicating with an elderly patient, especially for those who have hearing loss or organic brain disease.

The staff of the OARS Clinic at the Center for the Study of Aging at Duke University found that telephone interviews with older patients are effective for gathering initial information and for follow-up. The telephone enables the patient to take advantage of preserved bone conduction in mild to moderate hearing loss.

Inquire actively and systematically into the problems presented. The physician should inquire into common physical symptoms of late life (such as visual and auditory defects, falls, and weight loss) and typical psychosocial problems (death of a loved one, change in living arrangements, recent retirement, financial setbacks, feelings of decreased self-esteem, hopelessness, and anxiety).

Pace the interview. The elderly patient must be given enough time to respond to the physician's questions. The elderly are not, as a rule, uncomfortable with silences, which give them an opportunity to formulate answers to questions, and to elaborate on certain points. A slow and relaxed pace in the interview will do much to decrease anxiety.

Pay attention to nonverbal communication. The physician should be alert for changes in facial expressions, gestures, postures, and touch as auxiliary methods of communication in the elderly. These nonverbal signs can provide considerable information about conditions such as depression or anxiety.

Touch may also be an effective way to relax and make contact with the elderly patient. As a rule, the elderly are less inhibited than the young about physical touch. Holding the patient's hand or resting your hand on his arm may be very reassuring.

Be realistic but hopeful. Physicians who work with the elderly often deny the problems of late life. But neither the patient nor the physician believes phrases like "You'll live to be a hundred," or "It's nothing to worry about," and the physician should avoid using them. He/she should never abandon all hope for a particular patient, but should work in the here and now, avoiding unrealistic expectations. Two or three pain-free days may be most rewarding to the patient dying of cancer, a fact too often overlooked by the frustrated physician.

Continue the relationship with the elderly patient. The internist and family physician should avoid, as much as possible, permanent transfer and termination of care of elderly patients. A visit to the physician's office is often a social event in the elderly patient's life. The physician and other health care personnel become important individuals to the elderly. Getting "well" may mean the loss of contact with treasured associates.

Many clinicians working with the elderly have found that regular but infrequent checkups are quite reassuring for elderly patients. Most of them will not abuse an open door policy.

ASSESSMENT OF PRESENT PSYCHOLOGICAL FUNCTIONING

In this presentation we will not discuss formal psychological testing as it might be carried out by a clinical psychologist or a psychometrics technician or laboratory. We will focus instead on evaluations which can be performed during an initial psychiatric interview.

Evaluation of Cognitive Functioning.

Patients in this age group (65 and older) are at high risk for cognitive impairment. For this reason the *presence* and, when present, the *degree* of cognitive deficit must be ascertained. While many methods are available, one of the simplest, most reliable and valid methods is the Short Portable Mental Status Questionnaire developed by the author.[1] It consists of 10 cognitive performance items which test orientation, short-term memory, long-term memory, information necessary for activities of daily living, and capacity for serial mathematical operations. The test questions are reproduced below.

Each question must be scored as correct or incorrect. The total number of errors constitutes the score in the SPMSQ.

The test is sensitive to educational attain-

SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

Eric Pfeiffer, M.D.

Instructions: Ask questions 1-10 in this list and record all answers. Ask question 4A only if patient does not have a telephone. Record total number of errors based on ten questions.

+	−	
____	____	1. What is the date today? ____ Month ____ Day ____ Year
____	____	2. What day of the week is it? ____
____	____	3. What is the name of this place? ____
____	____	4. What is your telephone number? ____
____	____	4A. What is your street address? ____ *(Ask only if patient does not have a telephone)
____	____	5. How old are you? ____
____	____	6. When were you born? ____
____	____	7. Who is the president of the U.S. now? ____
____	____	8. What was President just before him? ____
____	____	9. What was your mother's maiden name? ____
____	____	10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down.

____________ Total Number of Errors

To be Completed by Interviewer

Patient's Name:__________________________________Date____________

Sex: 1. Male
2. Female

Race: 1. White
2. Black
3. Other

Years of Education:____________________

1. Grade School
2. High School
3. Beyond High School

Interviewer's Name:____

Copyright © E. Pfeiffer, 1974. All rights reserved.

ment. For persons with 9–12 years of education (high school), the following scoring system applies:

0–2	ERRORS	INTACT INTELLECTUAL FUNCTIONING
3–4	ERRORS	MILD INTELLECTUAL IMPAIRMENT
5–7	ERRORS	MODERATE INTELLECTUAL IMPAIRMENT
8–10	ERRORS	SEVERE INTELLECTUAL IMPAIRMENT

For persons with 8 or fewer years of education, one additional error is allowed for each scoring category. For persons with more than 12 years of education, one less error is allowed for each category.

The test is not capable of distinguishing between reversible organic brain deficit (delirium) and irreverisible organic brain deficit (dementia). However, it can be used repeatedly, over days, weeks, months, or years, to quantitatively follow the course of drug-induced delirium or of Alzheimer's type of senile dementia, for example.

There are two sets of practical implications which stem from the results of this test. A finding of "intact intellectual functioning" means that the patient is, from an intellectual standpoint, capable of living independently, capable of understanding instructions and of taking his own medication as prescribed. No further diagnostic studies of intellectual functioning are generally indicated. Evidence of "moderate" or "severe" intellectual impairment should initiate a detailed work-up to evaluate the cause or causes of the cognitive deficit, with a special effort to discovering reversible causes of cognitive impairment. If no reversible cause of the deficit can be discovered, then additional studies should be carried out to determine the type of irreversible organic deficit (dementia) which exists, (i.e. Alzheimer's type of senile dementia, multiple infarct disease, etc.). Patients with "moderate" intellectual impairment generally can still perform many of the activities of daily living independently but they need supervision with more complex activities such as handling of money or taking of medication. Patients with "severe" intellectual impairment in most cases require continuous supervision of their activities, cannot safely live alone, and require daily assistance with many of the activities of daily living. Cases falling into the category of "mild intellectual impairment" are really in a borderland. In general, additional or continuing observation will determine whether they should be regarded as "intact" or as "moderately impaired". It is not known whether such cases constitute variants of "normal aging" or whether they constitute early cases of developing delirium or dementia. This can generally only be decided by following the patient over time.

Evaluation of Functional Psychiatric Symptomatology

It is also valuable to document the presence and the degree of functional psychiatric symptomatology in the initial contact with patients. The author has developed the Short Psychiatric Evaluation Schedule (SPES), reproduced below, for this purpose. In many ways it is analogous to the Short Portable Mental Status Questionnaire in that it, too, produces a numerical score from 0 to 15, indicating extent of psychiatric symptomatology.

The test consists of 15 questions to be answered by the patient with either a "yes" or a "no". Each question can be answered in a healthy or in a pathological direction. The pathological responses are precoded in capitals (YES, NO) while healthy responses are coded in small letters (yes, no). The number of questions answered in the pathological direction (YES, NO) constitutes the score on the SPES. Scores from 0–3 imply an absence of significant func-

SHORT PSYCHIATRIC EVALUATION SCHEDULE

Eric Pfeiffer, M.D.

Please answer the following questions *Yes* or *No* as they apply to you now. Do not skip any questions. Occasionally a question may not seem to apply to you, but please *circle* either Yes or No, whichever is more nearly correct for you. (No = 0, Yes = 1)

1.	Do you wake up fresh and rested most mornings?	yes	NO
2.	Is your daily life full of things that keep you interested?	yes	NO
3.	Have you, at times, very much wanted to leave home?	YES	no
4.	Does it seem that no one understands you?	YES	no
5.	Have you had periods of days, weeks or months when you couldn't take care of things because you couldn't "get going?"	YES	no
6.	Is your sleep fitful and disturbed?	YES	no
7.	Are you happy most of the time?	yes	NO
8.	Are you being plotted against?	YES	no
9.	Do you certainly feel useless at times?	YES	no
10.	During the past few years, have you been well most of the time?	yes	NO
11.	Do you feel weak all over much of the time?	YES	no
12.	Are you troubled by headaches?	YES	no
13.	Have you had difficulty in keeping your balance in walking?	YES	no
14.	Are you troubled by your heart pounding and by a shortness of breath?	YES	no
15.	Even when you are with people, do you feel lonely much of the time?	YES	no
	TOTAL SCORE	________	

To Be Completed by Interviewer

Patient's Name:______________________ Date______________

Sex: 1. Male Race: 1. White
2. Female 2. Black
3. Other

Years of Education:______________ 1. Grade School
2. High School
3. Beyond High School

Interviewer's Name:______________________

Copyright © E. Pfeiffer, 1975. All rights reserved. SPES for Interviewer Administration

tional psychiatric symptomatology. Scores from 4–5 constitute a borderland of uncertainty. One should be suspicious of possible significant psychopathology, but other data from the history and from the remainder of the evaluation must be used to decide whether significant psychopathology exists. Scores greater than 5 are indicative of definite psychopathology, while scores of 10 or greater indicate extensive psychopathology (Pfeiffer, 1978).

SPES scores of 5 or greater are a strong indication that functional psychopathology is present. Forms of psychopathology tapped by the test include depression, anxiety, paranoia and hypochondriasis, disorders particularly prominent in this age group.[8,9,10] The test is not capable of detecting mania in older patients, unless concomitant anxiety and delusions are also prominent. The SPES score alone is not capable of distinguishing between depression, anxiety, paranoia and hypochondriasis. Extremely high scores in the range from 12–15 are generally seen only in severely hypochondriacal patients or in floridly psychotic patients.

The SPES is sensitive to change in the patient's clinical conditions. Thus the test should be repeated at intervals (every month or every three months) to document progress being made in treatment.

ASSESSMENT OF PAST PSYCHOLOGICAL FUNCTIONING

Assessment of past psychological functioning is aimed at discovering the repertoire of coping devices available to the patient, as evidenced by his or her previous use of these devices in adapting to earlier life circumstances and adversities. It is assumed that persons who have successfully adapted in the past are more likely to continue to do so than are persons who have made poor prior adjustments. Unfortunately, a simple checklist is not available in this regard. The clinical interview must be utilized to obtain the requisite information.

The interview must first establish what adversities and life changes the patient has previously experienced. Secondly, the interview must establish how the patient has previously coped with these life changes. The range of life experiences obviously varies enormously from individual to individual, with some experiencing few, others many distressing and dislocating events. Questions to which the interviewer must seek answers include: What have been the major dislocations the patient has experienced in the past? How profoundly was the patient initially disturbed by these events? What active steps did he take to respond to the situation? What were the residual effects of his experiencing the various situations? On the assumption that the past is, to a certain extent, prolog, an examination of the specific coping devices employed by the patient will be especially illuminating. In this regard the work of Anna Freud[11] on defense mechanisms and of Vaillant[12] on hierarchies of adaptive mechanisms, is particularly valuable. Also, the magnitude of the distress experienced, short-term and long-term, and the magnitude of the dislocating event, must be compared. From this kind of examination will emerge a well-developed picture of the patient's previous adaptive style, permitting the clinician some estimate of how the patient may be able to cope with his current predicaments.

In this connection it may be stated how remarkably adaptive many older persons have proven themselves to be when the history of their past adaptation is examined. This type of review is often helpful in pointing to specific adaptations to be considered in dealing with the patient's present circumstances and in fostering optimism that older patients will once again be able to successfully adapt.

ASSESSMENT OF PRESENT SOCIAL FUNCTIONING

An assessment of present social functioning is very important. Present social functioning is, to a significant extent, a proxy indicator of both past and present psychological functioning. Thus, on the one hand, the existence of a rich network of rewarding social relationships with family members and friends is, of itself, an indication of good present, and or past psychological functioning. On the other hand, the quality of the social network is also an important factor in restoring healthy psychological functioning when this has been temporarily disturbed.

Evaluation of Quality and Quantity of Present Social Contact

In this area inquiry is made concerning a variety of issues relating to the number of social contacts the patient regularly experiences:

How frequently did he speak with someone by telephone during the past week?

How frequently did he visit someone or someone come to visit him during the past week?

How many people does he know well enough to visit in their homes?

The quality of social contacts may be ascertained by questions such as these:

Do you have someone you can trust and confide in?

Do you find yourself feeling lonely?

Do you see your friends and relatives as often as you like to?

Evaluation of Social Support Available in the Social Network

In this area inquiry is focused not so much on the moment-to-moment social contacts but rather on longer-term social commitments other persons may have towards the patient. Questions aimed at elucidating the social support structure include:

Marital status—an intact marriage is a positive social support resource.

Living arrangements—living with relatives constitutes a positive social resource.

Availability of someone to provide transportation or emergency (short-term) care in case of illness.

Availability of someone to provide ongoing care in case of illness or disability for an indefinite period of time.

The availability of caregivers in the social environment is critically important in determining whether someone can receive treatment and care on an ambulatory basis or whether hospitalization or long-term institutionalization is required.

ASSESSMENT OF PAST SOCIAL FUNCTIONING

In instances where present social functioning is inadequate, it is extremely important to ascertain the patient's past level of social functioning. Where this was abundant, pleasurable, and supportive, having become dismantled only due to outside influence (death, illness, relocation), it should be quite possible to reestablish a meaningful social network. Where the person never had good social and supportive relationships, the task will be more difficult. Psychiatric treatment attentive to uncovering the obstacles to social interaction first need to be implemented before a rewarding and supportive social network can be built.

ASSESSMENT OF INFORMAL SOCIAL SUPPORT SYSTEMS IN THE COMMUNITY

While personal social resources are important in understanding and overcoming psychological distress, informal social support structures such as exist in neighborhoods, communities, congregate housing settings, church, racial, or ethnic groups, must also be assessed and utilized in treating elderly psychiatric patients. This type of assessment cannot be easily made through an office interview with the patient. It can be done more adequately when the clinician has full knowledge of the particular community environment. It can be done most optimally through a visit to the patient's own home, either on the part of the psychiatrist or on the part of an associated nurse, social worker, medical student or resident. The friendliness/hostility, the safety/dangerousness, the accesibility/remoteness of the environment can thus be assessed as can be the degree of recognition and/or integration of the patient into his community. Knowledge of these factors will lead to a realistic appreciation of not only how the patient functions during his one hour in the psychiatrist's office but in the environment in which he must function 24 hours a day. Both the opportunities for support as well as the limitations inherent in the environment will then be correctly appreciated and included in the design of an overall treatment plan for the patient. For the aim is never to merely foster adaptation of a patient to a hospital or office setting but adaptation in the natural setting to which the patient will return following treatment.

COMPREHENSIVE MULTIDIMENSIONAL FUNCTIONAL ASSESSMENT OF THE OLDER PATIENT

While the above aspects of psychosocial functioning must be assessed in all older persons with psychiatric symptomatology, a still more desirable approach to older patients in general is to perform a comprehensive multidimensional functional assessment. A standardized method for such assessment has been developed under the author's leadership during his tenure at the Duke University Center for the Study of Aging and Human Development.[11] The OARS* Multidimensional Functional Assessment Methodology provides for a systematic quantitative assessment of an older person in five major areas of functioning: (1) mental health; (2) physical health; (3) social resources; (4) economic resources; (5) capacity for the activities of daily living. The OARS Methodology also inventories the patient's own perceived need for a wide range of services including his perceived need for psychotropic drugs, counseling or psychotherapy, physical health services, transportation, social and recreational services, or assistance with relocation. The full interview schedule requires approximately 1 and ¼ hours for its completion. Formal training (two days of training) in the use of the interview schedule is strongly recommended to assure reliable and complete data gathering. Such training is available through the Duke University Center for the Study of Aging in Durham, N.C. or through the Department of Psychiatry at the University of South Florida in Tampa, Florida.

SUMMARY

It is obvious that many more areas of psychological and social functioning could be usefully assessed. However, what has been presented here in this deliberately brief chapter is a deliberately parsimonious set of assessment techniques which successfully capture the most critical aspects of psychological and social functioning of older people. Substantially more extensive assessment methodologies are certainly available; however, these have been found to yield incomplete data sets in elderly patients with the result that "more" is actually "less." In addition, the brief procedures outlined above have been specifically standardized *on older patients*, and have a known reliability and validity. The final emphasis on *portability* (the fact that they can be administered anywhere, in the home, in the office, at the bedside) provides the practitioner with an ever-present set of techniques, enhancing the likelihood that these techniques are not only available but will actually be used.

NOTE: The section of "Communicating with the elderly patient" is reprinted from *Geriatrics* © 1978, by Harcourt Brace Jovanovich, Inc.; the article entitled "Techniques for communicating with your elderly patient" was authored by Dan Blazer, M.D.

REFERENCES

1. Eisdorfer, C. Arousal and performance: Experiments in verbal learning and a tentative theory,

---

* OARS: Older Americans Resources and Services

in G. A. Falland (ed.) *Human Aging and Behavior.* New York: Academic Press, 1968.

2. Butler, R. N. and Lewis, M. I. *Aging and Mental Health.* St. Louis: C.V. Mosby, 1973.
3. Botwink, J. Cautiousness in advanced age. *Journal of Gerontology,* 21: 347, (1966).
4. Verwoerdt, A. *Clinical Geropsychiatry.* Baltimore: Williams and Wilkins, 1976.
5. Butler, R. N. The life review: An interpretation of reminiscence in the aged. *Psychiatry,* 26: 65 (1963).
6. Strain, J. J. and Grossman, S. *Psychosocial Care of the Medically Ill.* New York: Appleton-Century-Crofts, 1975.
7. Bunzel, J. H. Recognition, relevance and the de-activation of gerontophobia. *J. American Geriatrics Society,* 21: 77–80 (1973).
8. Pfeiffer, E. A short protable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *J. American Geriatrics Society,* 23: 433–441, 1975.
9. Busse, E. W. and Pfeiffer, E. *Mental Illness in Later Life:* Washington, D.C.: American Psychiatric Association, 1973.
10. Busse, E. W., Pfeiffer, E. *Behavior and Adaptation in Late Life.* Second Edition. Boston: Little, Brown, 1977.
11. Freud, A. *The Ego and the Mechanisms of Defense.* New York: International Universities Press, 1946.
12. Vaillant, G. E. Theoretical hierarchy of adaptive ego mechanisms. *Arch. Gen. Psychiatry,* 24: 107–118 (1971).
13. Pfeiffer, E. Ways of combining functional assessment data, in Duke-OARS: *Multidimensional Functional Assessment: The OARS Methodology.* Durham, North Carolina: Duke University Center for the Study of Aging and Human Development, 1978.

One of the most prevalent myths about the elderly is that they (as a group) live out the last years of their lives alone. Emphasize to your students that the majority of elderly 1) live with their spouse, 2) have 2 or more living children and, 3) live within 30 minutes of their children. More than 1/2 of the elderly see their children every day. Studies have indicated that there is a considerable amount of "give and take" in the form of mutual aid that exists between older parents and their children.

Ask the class members to give their own definition of a social support system. Do they consider themselves to be self-sufficient and independent? The class could discuss their own social support system after reviewing the text. Where do their friends come from?

Do most of their friendships stem from the workplace or from their children's school? For a great many of us, our social life, our friendships, do come from these sources. We naturally gravitate toward people who have interests in common with us. When we are young, these people usually work with us; they are the parents of our children's friends. These people live in our neighborhood, coach teams with us, lead scout groups with us, and often worship in the same church. These are the folks that we trade carpool days with and exchange babysitting favors with. This is an informal support system. Within this group are members of our family. These are people that we help and upon whom we call for help.

Have the class discuss what happens when the children are grown, the neighborhood population has changed, and retirement occurs. This support system gradually shrinks over the years, and when a major life style alteration occurs, it can rapidly diminish. Therefore, for someone with little or no talent for making friends, or for someone whose social skills have deteriorated, an event such as retirement can be devastating.

During the discussion, keep in mind and remind the class that a social support system is essential to independent functioning. It is seen as the major mechanism by which a person can engage with their environment and overcome isolation. As service providers, it is best to avoid reinforcing dependent behavior in our clients. If we do everything for our clients, providing for all of their needs, our good intentions can foster learned helplessness in our clients. This can be avoided by letting the older person know that they are expected to meet most of their own needs. In this way, we will reinforce independent action by the client.

Perhaps the class would like to construct a typical elderly Florida couple. John and Mary Smith come from Ohio. John is 66 and Mary is 59. John retired last year and they sold the home that they bought 40 years ago. They have raised three children. Have the class build a life for them here. What could happen to them? Look at all of the possibilities. How important is a social support system to them? How does one go about building a new one? Stress the idea of tailoring a social support system to an individual's needs and to his or her capabilities. Keep in mind what the text has to say about the effects of doing too much for someone. What is called for is some fine tuning.

SOCIAL SUPPORT

Name: ______________________________ **Date:** __________________

CIRCLE THE CORRECT ANSWER.

1. In meeting the needs of the elderly, it is best to:

   a. provide for a full continuum of needs
   b. meet only those needs which are life-threatening
   c. expect them to meet most of their own needs

2. A social support system is essential to independent functioning and is seen as the major mechanism whereby a person can overcome isolation and:

   a. engage with the environment
   b. late onset paranoia
   c. sensory deficits

3. Although the objective in most intervention is to build independence and less restrictive functioning, we often unintentionally reinforce dependent behavior resulting in:

   a. loss of control
   b. learned helplessness
   c. reciprocity

4. The need for physical support tends to increase with advancing age.

   a. True
   b. False
   c. Age is not a factor

5. When an individual is prevented from interacting with the world around them, the condition is called:

   a. loss of control
   b. environmental deprivation
   c. sensory dysfunction

6. ______________ are most at risk of environmental deprivation.

   a. Widows and minorities
   b. Newly retired people
   c. The "old-old"

7. Social isolation is ______________ of environmental deprivation.

   a. a cause
   b. a consequence
   c. both a cause and a consequence

8. The majority of elderly ____________ meet their own physical, social, and economic needs on their own or with just a minimum amount of help.

   a. can; but refuse to
   b. can
   c. cannot

9. Elderly women are ___________ at building their own social support network.

   a. very good
   b. often deficient
   c. equal with men

10. According to the "equity theory," the elderly

   a. should pay more for services
   b. should not be allotted more services than children
   c. put in and take out of each relationship

BEST COPY AVAILABLE

Social Support

1. c
2. a
3. b
4. a
5. b
6. c
7. c
8. b
9. b
10. c

BLANK PAGE

A literature review of internal and external changes on the mental and emotional status of elderly [illegible] reveals [illegible] social and emotional isolation to be the key intervening variables which disclose functional symptoms of mental disorders. Since organic pathologies of the brain are not the sole determinant of functional disorder, treatment modalities counteracting isolation will alleviate or reverse the symptomatic disorders whether or not brain pathologies due to aging are present.

Isolation and the Symptoms of Chronic Brain Syndrome

Philip Ernst, MD,[1] Barbara Beran, MA,[2]
Frances Safford, MA,[3] and Moris Kleinhauz, MD[4]

The concept of dualism, inherited from the philosophers of ancient times and redefined for modern man by Descartes, portrays the world as two independent spheres: matter and spirit, body and mind; things that can be perceived with the five senses, and those which are contained in the realms of intellect and emotionality which can neither be perceived nor measured objectively. This dualism continues to affect scientific thought today, and often interferes with our ability to grasp the complexity and interrelations of the actuality of the real world which exists as a unity. Indeed, this concept often blinds us to the unity of the physical structure of man's body and his emotional and behavioral functioning and cognition, and thus affects theoretical understanding and clinical procedures in the field of medicine to this day.

Adhering to a misunderstanding of the conditions of the scientific method in medicine, we have all too often limited our approach to both the perception and treatment of the physical aspects of health and illness which are more easily quantified. We have worn blinders which prevent us from appreciating the complexity of human physical and emotional existence, and tend to recognize only that which can be mathematically assessed and diagrammed. We have developed sophisticated methods of measuring matter, and our focus has been on the physical causes of disturbance and the physical means of treatment of these causes. Though this attitude may be found throughout the field of medicine, our concern in this article will be to trace its effects on our work with the elderly. Our primary concern is to clarify the interrelationship of the physical and nonphysical aspects of mental health and illness.

Traditionally, morphological changes in the brain due to age have been regarded as an inevitable and natural process. These changes were thought to have a purely uni-directional and causative relationship to the emotional, cognitive, and behavioral characteristics manifested by the elderly. Studies at Duke University, and the findings of Rothchild (1941), however, demonstrated that there is no direct relationship between morphological changes in the brain and the clinical symptoms used in the diagnosis of Organic Brain Syndrome. Clinical symptoms may occur without brain changes, and such change may be manifest without functional symptomology. We propose, therefore, to regard the relationship between the organic structure of the brain and the emotional, cognitive, and behavioral performance of the aging person in a circular model, in which causation may go in either direction. The determining factors are the intervening variables of relative isolation which alter the functioning of the person, produce affective disorders, and disturb cognition. Morphological change alone is not always sufficient unless it is mediated by isolation, and thus results in functional disturbance. Indeed, it is possible that such isolation, as it leads to sensory deprivation, will produce morphological change which in turn will increase the degree of isolation.

---

[1] Director, Psychogeriatric Unit, Community Mental Health Ctr., Yafo, State of Israel, Ministry of Health, P.O. Box 8676, Tel Aviv - Yafo, Israel.

[2] Director of Research & Evaluation, Community Mental Health Ctr., Yafo.

[3] Psychologist, Ctr. for Drug Rehabilitation, Yafo.

[4] Director, Community Mental Health Ctr., Yafo.

In a majority of disturbed elderly persons, it is possible to find isolation of several kinds: (1) emotional isolation: the person rejects friends, withdraws from social activities, and withdraws into apathy; (2) social isolation: peers age and die, the person is left widowed, children marry and become wrapped in their own families and households, retirement separates the person from the web of occupational interactions; (3) physiological isolation: age brings deterioration of the sensory receptors producing difficulties in hearing and seeing, ambulation is reduced, restricting the exposure to persons outside the home. These isolations tend to exacerbate depressive and paranoic reactions, as well as neurotic traits accumulated in earlier years which can no longer be dealt with using the previous defense mechanisms. In turn, these affective disturbances contribute to increased isolation. If I suspect that my neighbor is maligning me or stealing from me then I will not talk with him, and he will in turn avoid me. If depression leads me to lie in bed all day, I have no time or energy to relate to others.

We stress the necessity to downplay the role of morphological change in the syndrome of emotional, cognitive, and behavioral disorders in the aged. The tendency to diagnose this constellation of disorders as inevitably linked to organic brain disorder has led, all too often, to absolving the care-taker from the responsibility of actually providing therapeutic treatment for the elderly patient. As Palmore put it ". . . the belief that mental illness in old age is inevitable, untreatable, disabling, and irreversible becomes a self-fulfilling prophecy. It leads to lack of prevention and treatment which in turn tends to confirm the original belief" (Palmore, 1973). An acknowledgement of the interaction of the physiological, social, cognitive, emotional, and behavioral factors, and a stress on the importance of isolation, will bring us to recognize that it is possible to treat the aged who suffer from mental and cognitive disorders. It focuses our attention, as therapists, on factors which can be manipulated and which offer a point of entry into the problems of the elderly.

There is also ample evidence to show that the general impact of the quality of perception is not merely a cognitive process, but has definite somatic implications. Researchers have demonstrated that interference with sensory function affects the morphology of the individual cell structure involved in the particular sensory process, as well as produces functional and biochemical changes in the organism. Among the morphological changes noted as a result of visual deprivation have been changes in the electrical activity of the cortical and subcortical regions after early deprivation in a rabbit (Shiliagina, 1973), changes in the polyribosome aggregation in the visual cortex of a rat (LeVay, 1977), changes in the binocular neurons in the visual cortex after single eye deprivation of a rabbit (Van Sluyters, 1974), reduction in the density of synopses and in the number of synoptic vehicles in the visual cortex after monocular deprivation in the rabbit (Vrensen & de Groot, 1975), perceptual as well as morphological changes in a rat (Chow, 1974; Ganz, 1974), myopia in rats deprived of distant vision during development (Rose, 1974), and cortical suppression of the retino-collicular pathways (Mitros, 1976) found a different electrophoretic pattern of soluble proteins in the sensory cerebral cortex of visually deprived kittens than that present in normal kittens, and Herman (1974) documented that monocular occlusion impairs steroscopic acuity.

Dealing with the other sensory systems, Meisami (1976) found that olfactory deprivation affects postnatal growth of the olfactory bulb in the rat. Pimenides (1977) found class III malocclusion in the rat subjected to oral facial sensory deprivation, and Fulgheri (1976) documented that total isolation of rats (tactile and normal social contact) produces a reduction of testosterone and estradiol 17B plasma levels.

The above discussed researchers found specific morphological changes which were a result of sensory deprivation. We now turn to studies which focus on functional changes brought about by sensory deprivation. In laboratory experiments with animals, Zublock (1975) found early visual deprivation affected the visual discriminatory learning of cats; Fioretti (1974) found that male wistar rats blinded or kept in constant darkness lost their circadian rhythms of body temperature; Hinkel (1974) found that visual isolation reduced aggression in the Siamese fighting fish *(Betta Slendens)*; Calhoun (1975) found that visual deprivation modified the retrograde amnesia of a rat after electroconvulsive shock; and Thor (1975) showed that deprivation of a rat produces total suppression of irritable aggression.

Research related to sensory deprivation of human beings has uncovered this additional data: visual deprivation causes disturbance in depth perception (Tees, 1974); visual sensory restriction increased the effect of an imagined stimulus on a suggestibility measure (King & Lunis, 1974); subjects left in darkness for one week had a significant increase in olfactory sensitivity and gustatory threshold increases to NaCl and sucrose, and stable threshold to HCl and quinine (Zubeck, 1967); auditory deprivation affected visual resolving power (Bross, 1974); sensory deprivation and social variables affect recalled dreams (Dallett, 1974); and bed rest in the presence of sensory deprivation produces changes in perception and motor behavior (Downs, 1974).

A more comprehensive explanation of the effects of a sensory deprivation has been provided by Freedman (1961):

> In sensory deprivation the subject is presented with an undifferentiated, homogeneous, sensory environment which provides no useful information for spatial orientation. The organism seeks automatically and continuously ordered relationships in his perceptual environment. When presented with a disordered environment, as in sensory deprivation, his previously acquired spatial schemata becomes useless; what is worse, he cannot modify the old schema since there is no information in his stimulus field to maintain any schema at all. But spatial orientation is vital to the organism. It is a process of seeking ordered relationships where there are none. Striving to incorporate nonorder into previously existing schemata degrades the perceptual frame of reference. With the breakdown of the internalized frame of reference it becomes difficult to structure the environment, to impose constancies and stabilities on the perceived visual field; thus objects seem to change form and size and color.

Head is quoted by Freedman (1961) as accounting for the disorientation involved in sensory deprivation by defining the body schemata as an integrate of all sensation, perception, memories and images continuously built up and altered by new activity and new stimulation and used continuously for reference in locating new sensation and correctly initiating new movements.

Sensory deprivation limits the organism's environment to a sensory tepid bath that lacks the variety necessary for the operation of cognitive ordering. Freedman (1961) shows that the effect of this deprivation is to increase the disorder of the internal schemata, and therefore to render the schemata useless. Without further input, the schemata cannot be reordered and without the reordering the perceptual and cognitive systems cannot function.

A living organism differs from a nonliving physical system because of its ability to increase the differentiation of its parts, and the complexity of its organization. Physical systems, by contrast, are governed by the physical law of entropy which leads to ever increasing homogeneity, uniformity, and lack of differentiation. A continual input of perceived information from the environment is necessary to permit the living organism to maintain or increase its level of differentiation and organization. Thus, information, by reducing entropy, is necessary to the vitality of the living organism (Weiner, 1948). We may consider, therefore, that sensory deprivation, and the resulting isolation from the perceived environment, deprive the organism of necessary information, and consequently deprive it of the entropy-decreasing process which we call "life." (For further amplification of the linkage of information and entropy, see Rappaport, 1971).

Relative sensory deprivation is, in part, a byproduct of the physical changes associated with aging: progressive loss of function of the organs of sight and hearing, and increased immobility caused by physical infirmities. These changes tend to occur gradually, giving the person time to adjust to them. By contrast, there are a complex of social changes linked with aging in most western societies, which tend to confront the person suddenly. Thus, a person retires on a given date, passing from the framework of a useful economic role which has been a large measure of his social identity to the relatively negative and ill-defined role of pensioner. Suddenly, there is no reason to get up in the morning, and no self-definition to offer to others but a reference to the past — I was . . . The person is suddenly aimless, unsure of how to pattern his days, and without the former stimulations from a varied social and occupational environment. The adjustment may be short or long, and presocialization or anticipatory preparation during the years prior to retirement may help, but it is possible that the initial period of shock may result in a sharp loss of stimulation and a withdrawal into disengagement from the web of society and social interactions which, in turn, feeds on itself and becomes a pattern of isolation. Adjustment to these changes depends as well on the person's pre-morbid personality structure. In addition, it is important to remember that it is an aging brain which is confronted with increased deprivation, but may lack the resiliency to cope with it.

Disengagement, as first outlined by Cumming and Henry (1961) pointed to a linear, irreversible pattern through which the elderly person separated from society through withdrawal from his former social roles, a reduction in the number of his former contacts, and a change in the intensity and quality of those relationships which were maintained. In turn, society tends to reduce the demands made on him, frees him from many structural restraints, and, in effect, desocializes him. Since this first exposition, critics have noted that disengagement is only one of the possible processes of aging, and that the older person may in fact remain active and engaged (see review of this debate in Butler & Lewis, 1977). Indeed, we share the belief that active participation as long as possible, and the provision of substitute activities to replace those that must be relinquished, is desirable to maintain the stimulation necessary to preclude mental disorders. For example, the presence of grandchildren and a satisfying relationship with them, may replace the loss of other role partners. However, the extent to which the older person is channeled into disengagement is in large measure an artifact of the general, overall character of the society in which he lives, and of his particular location in that society. Not simply the fact that he is aging, but the individual set of meanings which he gives to his network of previous social bonds and the resulting experienced deprivation of his present life, will determine the extent to which he will experience sensory deprivation (Hochschild, 1975). Thus it is incumbent on the clinician to understand the position of the old in the society in which his patients live, and the idiosyncratic interpretations and meanings which his patient has accumulated from previous cultural and social frameworks and psychological adaptations. This understanding will enable the clinician to design appropriate patterns of activity and processes of re-engagement.

In general, the old person finds himself in a world of decreasing familiarity. The people, places, and things which were the yardsticks of his existence disappear as the years go by. A man who has been the expected "breadwinner" is required, often by law, to retire — a woman whose primary self-identity came from her position as mother and homemaker watches her children leave, and may be forced by infirmity to become a "guest" in the home of another person, or a resident in an institution. One's peers begin to die, and the possibility of one's own death becomes real. Fear of death may lead to a heightened body consciousness. Life loses its flavor, the environment is drained of meaning, the degree of extroversion declines (Post, 1970), and there is a tendency toward social isolation and a consequent degree of sensory deprivation. Thus, the elderly person is robbed of the external touchstones that had provided a flow of information and supported the internal schemata.

In addition, the older person experiences a decrease in the efficiency of the sensory receptors as Busse (1967) reports: (1) pain is less specific; (2) smell diminishes; (3) taste decreases; (4) there are changes in presbyerisis (hearing) and presbyopia (sight); and (5) there is failing health and unreliable memory. As a result, there is a gradual and continual decrease in the emotional, social, and physical stimuli needed for mental health, and of the information needed to maintain the functions of life. These changes may produce a situation not unlike that simulated in sensory deprivation experiments in the laboratory, with similar effects. Oster (1976) notes that cells require continuous stimulation in order to grow and function, and that sensory deprivation means a lack of stimulation which will hasten cell degeneration such as that associated with aging. In turn, these physical limitations on the reception of external stimuli may be exacerbated by the negative reinforcement of depression. The older person who experiences depression (10% of the members of a social club for the elderly according to our findings — Ernst et al., 1977a) tends to concentrate on his fears and to reject stimuli from the outside. Wrapped up in his own anxieties, his threshold to stimuli is raised and reception is further blocked.

It should be clear that a portion of the mental and emotional illnesses characteristically found in the old derive from organic causes. Pathological entities such as Altzheimer's disease, and atherosclerosis with stroke, stem from diffuse destruction of brain cells, chronic degenerative or vascular disease, or inflammatory and neoplastic processes, and produce emotional,

BEST COPY AVAILABLE

cognitive, and behavioral symptomology regardless of the social or psychological milieu. However, the success of treatment aimed at the reduction of isolation in the improvement of patients classed as organic brain syndrome cases (Ernst et al., 1977b) points to the necessity of a focus on the role of isolation and sensory deprivation in producing symptomology which appears due to morphological changes in the brain alone. Pre-senile organic forms of organic brain syndrome are relatively rare, and the diagnosis of organic brain syndrome in the aged is based on clinical observation of function and can be confirmed only in a post-mortem examination. Therefore, it seems reasonable to provide sensory stimulation and isolation-reducing therapies to most clinically-diagnosed cases of senile psychosis and/or chronic brain syndrome, in addition to any other medico-pharmacological therapies such as anti-inflammatory or vascular treatment.

We assume that the absence of stimulation involves deterioration of the patient's physical activity, social participation, intellectual status, and overall personality integration. This deterioration is manifested in symptoms which are classed as indicators of chronic brain syndrome. Arie (1973) linked dementia of the elderly to restricted mobility and sensory deprivations deriving from deafness and/or blindness. Loss of reception of information from the external world makes that world a lonely and frightening place, and in depression or anxiety the person tends to withdraw into an internal world of hallucination and to project apathy to his surroundings. Wells (1975) agrees, as he states "faltering contact with the environment and the gloom of isolation are the major causes of the problems of the aged. As sight, hearing, smell, touch, and taste are eroded, apathy takes over." In a study of sensory loss and behavioral defects among nursing home residents in New York, O'Neil (1975) found a clear correlation between sensory loss and senile manifestation.

The connection between isolation and mental illness was noted by Fromm-Reichman (1959) who wrote, "the longing for interpersonal intimacy stays with every human being from infancy throughout life, and there is no human being who is not threatened by its loss." She adds that the particular kind of loneliness with which she is concerned is "nonconstructive, if not disintegrative, and it shows in, or leads ultimately to, the development of psychotic states. It renders people who suffer it emotionally paralyzed and helpless." She suggests that "the experience in adults usually described as a loss of reality or a sense of world catastrophe can also be understood as expressions of profound loneliness." She connects these changes to mental disturbance as she notes that loneliness leads "ultimately to the development of psychotic states." Lonely people, according to her, are rendered "emotionally paralyzed and helpless." Thus, those elderly persons who fall into the cycle of sensory deprivation, isolation, depression, apathy, and fear live in a world that no longer seems to make sense.

Thus, to summarize, we have seen that the social, emotional, and physical changes of aging that act to limit input from the outside world combine to create a serious state of isolation and loneliness in the elderly. There is a changed social environment, a loss of past sources of emotional satisfaction and pride of accomplishment, a constriction of the circle of family and friends, and the experience of increased physical limitations on mobility and the reception of external stimuli. If elderly persons, as a result, experience cognitive breakdown, the cause need not be sought only in pathological changes in the brain, but may be a response to this changed world in which they find themselves. The old person whose response to the questions of the Mental Status Questionnaire of Goldfarb (1964) is "I don't know, because there is no need to know — if I go out someone takes me and brings me home," or the one who doesn't know what day it is because there is nothing which distinguishes one day from another, may demonstrate significant cognitive development when and if the stimuli in his environment make such knowledge useful and possible (Ernst et al., 1977b).

It is clear that mental health problems among the elderly are circular in pattern of cause and effect. The outcome of the decline in the efficiency of the sensory receptors is a decrease in the stimuli received by the brain. Lacking stimulation, the cells may atrophy, memory and ability to manipulate the environment may fail, leading to a profound sense of disorientation, anxiety, and fear. These symptoms may culminate in depression and apathy. In turn the depression and apathy may act to more completely block the reception of stimuli, with a resultant state of isolation. Here, the cycle begins again, as sensory stimulation is further decreased. Uninterrupted, the process may lead to total cognitive breakdown. However, this scheme equally points to opportunities to intervene in the cycle and even to reverse it.

A review of the literature shows that not only are many of the effects of sensory deprivation in laboratory experiments reversible (Freedman, 1975; Kamysheva, 1976; Van Hof & Van Denin, 1976) but that work with the elderly to counteract the effects of isolation and lack of sensory stimulation has proved successful in impeding mental illness, and alleviating the symptomologies classed as chronic brain syndrome.

The diagnosis of chronic brain syndrome refers to a cluster of clinical symptoms consisting of disorientation concerning time, place, and persons; impairment of memory, intellectual functions such as comprehension and calculation and judgment; and lability and shallowness of affect. In an elderly person, these symptoms are said to result from diffuse impairment of the brain tissue due to the deteriorating processes of age (American Psychiatric Assoc., 1968). Clinically, there is a picture of loneliness and isolation from the surroundings and a depersonalization and alienation from one's own body. If the therapist, using our approach, addresses himself to the problems of isolation in all their aspects, and increases the external stimuli, the results, in many cases of diagnosed chronic brain syndrome are remarkable. Powell (1974) studied the effects of a 12-week exercise period on 30 aged psychiatric patients. Although he found no improvement on the behavioral scale, he did find marked improvement on two out of three cognitive tests he administered. Both Burnside (1974) and McCorkle (1974) noted positive effects following even minimally increased physical touch stimulation of regressed patients. Bowers (1967) found considerable improvement in patients with significant degrees of brain syndrome following 6 mo of participation in remotivation groups which were designed to resocialize these patients. Similar effects were obtained with patients diagnosed as suffering from dementia (Brook, 1975), probably because the symptoms used to diagnose dementia show much overlap with those used to diagnose chronic brain syndrome despite the more pronounced disturbance of thought processes associated with the former.

Our own research based on a conceptualization of the central importance of reduction of isolation in the treatment of psychiatric problems in the aged (Ernst & Badash, 1977), has shown the efficacy of this approach (Ernst et al., 1977a, b, 1978). A group of six elderly patients with a diagnosis of chronic brain syndrome according to Goldfarb's standardized Mental Status Questionnaire (1964) were provided with 3 mo of bi-weekly sensory stimulation and group therapy. They showed marked improvement on tests and clinical observation, with the most substantial improvement being that shown on before and after tests for chronic brain syndrome. (Ernst et al., 1977b). Clinical observation of these same persons shows that one year after the conclusion of the therapy they seem to demonstrate a continued social interaction with each other and a less isolated response to their surroundings. Since this experiment, we continue to apply this method to other selected groups with similar success. Folsom (1968) seemed to have a similar experience by treating 68 patients through the repetition of simple factual information, such as dates of the year. Seventeen of his subjects progressed sufficiently after one year of this increased external stimulation so that it was possible to transfer them to a more advanced group.

Thus, we conclude by stating that we believe that the therapist must not focus only on the organic factors of the aging brain but must stress the effects of the environment. He should conceptualize the relationship of organic and functional factors together with the development of mental disorders in the elderly as a cyclical process in order to find new tools for the treatment of his elderly patients. What has all too often been called chronic brain syndrome may be viewed as a complex of symptoms found among elderly persons who have, because of a combination of internal and external changes in their life, become isolated. Alleviation of this isolation may permit the therapist to treat those patients formerly called untreatable, and offers exciting leads toward the provision of preventative therapies to forestall future disorders in presently healthy, but aging, persons.

References

American Psychiatric Assoc. *Diagnostic and Statistical Manual of Mental Disorders*, 2nd ed., Washington, 1968.

Arie, T. Dementia in the elderly. *British Medical Journal*, 1973, *4*.

Bowers, M. B. Brain syndrome and behavior in geriatric remotivation groups. *Journal of Gerontology*, 1967, *22*.

Brook, P. Reality orientation — a therapy for psychogeriatric patients. *British Journal of Psychology*, 1975, 127, 42–45.

Bross, C. Dissertation abstract. Univ. of Manitoba, 1974, 35, 5B, 2458.

Burnside, I. M. Sensory stimulation with regressed aged patients. *American Journal of Nursing*, 1974.

Busse, E. W. Streeker Lecture. Univ. of *Pennsylvania Reports*, 1967.

Butler, R. N., & Lewis, M. I. *Aging and mental health: Positive psychosocial approaches*. C. V. Mosby, St. Louis, 1977.

Calhoun, K. Visual deprivation and retrograde amnesia. *Journal of Comparative Physiological Psychology*, 1975, *88*, 373-377.

Chow, K. L. Changes in the visual system of the rabbit after visual deprivation. *Experimental Neurology*, 1974, *42*, 429–447.

Cumming, E., & Henry, W. *Growing Old*. Basic Books, New York, 1961.

Dallett, J. Dissertation abstract. Univ. of California, 1974, 34, 11B, 5703-5706.

Downs, F. Sensory deprivation. *American Journal of Nursing*, 1974, 7, 434–438.

Ernst, P., & Badash, D. Psychiatric problems of the aged: A new approach more useful for both patient and doctor. *Israel Annals of Psychiatry and Related Disciplines*, 1977, *15*, 12-15.

Ernst, P., Badash, D., Beran, B., Kosovsky, R., & Kleinhauz, M. Incidence of mental illness in the aged: Unmasking the effects of a diagnosis of chronic brain syndrome. *Journal of American Geriatrics Society*, 1977, *25*, 371-375. (a)

Ernst, P., Beran, B., Badash, D., Kosovsky, R., & Kleinhauz, M. Treatment of the aged mentally ill: Further unmasking of the effects of a diagnosis of chronic brain syndrome. *Journal of American Geriatrics Society*, 1977, *25*, 466–469. (b)

Ernst, P., Badash, D., Beran, B., Kosovsky, R., Lerner, K., & Kleinhauz, M. Sensory stimulation of elderly patients: Preliminary report of the treatment of patients with chronic brain syndrome in an old age home. *Israel Annals of Psychiatry and Related Disciplines*. (in press)

Fioretti, O. Visual deprivation of the rat. *Life Science*, 1974, *14*, 211-219.

Folsom, J. C. Reality orientation therapy. *Journal of Geriatric Psychiatry*, 1968, 1, 291-307.

Freedman, S. J. Perceptual changes in sensory deprivation. *Journal of Nervous and Mental Diseases*, 1961, *132*, 17–43.

Freedman, S. J. Sensory deprivation. *Psychoanalytic Quarterly*, 1975, *24*, 62-80.

Fromm-Reichman, F. Loneliness. *Psychiatry*, 1959, *22*.

Fulgneri, D. Isolation in rats. *Institute of Zoology Florence Experientia*, 1976, *32*, 114–115.

Ganz, L. Results of visual deprivation. *Brain Research*, 1974, *20*, 67-87.

Goldfarb, A. I. The evaluation of geriatric patients following treatment. In P. H. Hoch & J. Zubin, *Evaluation of Psychiatric Treatment*. Grune & Stratton, N.Y., 1964.

Herman, J. Monocular occlusion impairs stereoscopic acuity. *Psychophysics*, 1974, *16*, 222-228.

Hinkel, T. Visual isolation and aggression. *Psychiatric Research Reports*, 1974, *34*, 1323-1326.

Hochschild, A. R. Disengagement theory: A critique and proposal. *American Sociological Review*, 1975, *40*, 553-569.

Kamysheva, K. Changes in the energy processes of the mitochondria of visually deprived animals. *Byulleten Experi Biology & Medicine*, 1976, 9, 1066-1068.

King, D., & Lunis, G. Effect of visual sensory restriction on a suggestibility measure. *Journal of Clinical & Experimental Hypnosis*, 1974, *2*, 239-248.

LeVay, S. Visual deprivation of the rat. *Brain Research*, 1977, *119*, 73-66.

McCorkle, M. *Effects of touch in seriously ill patients*. Univ. Iowa, Iowa City, 1974.

Meisami, E. Effects of olfactory deprivation. *Brain Research*, 1976, *107*, 439–444.

Mitros, K. Electrophoretic patterns of insoluble proteins in visually deprived kittens. *Acta Neurobiologica Experiment (Warsz)*, 1976, *36*, 407–416.

O'Neil, P. M. Sensory loss and senile manifestation. *Journal of Abnormal Psychology*, 1975, *84*, 579-582.

Oster, C. Sensory deprivation of the aged. *Journal of American Geriatric Society*, 1976, *24*, 461–464.

Palmore, E. B. *Mental illness in later life*. E. W. Busse (Ed.), American Psychological Assoc., Washington, 1973.

Pimenides, M. Z. Effects of oral facial sensory deprivation. *Journal of Orthodontia*, 1977, *71*, 94-102.

Post, F. Disturbances in memory and thinking. *Gerontologist*, 1970, *2*, 627-630.

Powell, R. R. Effect of exercise therapy on cognitive and behavioral characteristics of hospitalized geriatric mental patients. *Journal of Gerontology*, 1974, *29*, 157-161.

Rappaport, A. Mathematical aspects of general systems analysis. In F. Katz (Ed.), *Contemporary Sociological Theory*. Random House, New York, 1971.

Rose, L. Distant vision deprivation of rats. *Vision Research*, 1974, *14*, 1029-1032.

Rothchild, D. Poor correlation between pathologic and clinical findings in aged. *Diseases of Nervous System*, 1941, *2*, 49-54.

Shiliagina, N. M. Early deprivation in rabbits. *Zhurnal Uchonych Nervia Deert*. Russian-English abstract, 1973, *23*, 1066-1073.

Tees, R. C. Effect of sensory deprivation on depth perception. *Journal of Comparative Physiological Psychology*, 1974, *86*, 300-308.

Thor, D. H. Sensory deprivation. *Psychiatric Research Reports*, 1975, *37*, 432–434.

Van Hof, & Van Denin, J. Sensory deprivation. *Brain Research*, 1976, *104*, 233-241.

Van Sluyters, R. E. Monocular sensory deprivation. *Experimental Brain Research*, 1974, *19*, 196-204.

Vrensen, G., & de Groot, D. Monocular deprivation in the rabbit. *Brain Research*, 1975, *93*, 15-24.

Weiner, N. Cybernetics. John Wiley & Sons, New York, 1948.

Wells, C. E. C. Sensory loss in the aged. *Practitioner*, 1975, *215*, 593-599.

Zubek, J. P. Sensory deprivation. *Canadian Journal of Psychology*, 1967, *21*, 337-345.

Zubiock, T. A. Early visual deprivation. *Acta Neurobiologica Experiment (Warsz)*, 1975, *35*, 389-399.

The instructor should emphasize some of the following points during the lecture. The symptoms of mental health are often determined from subjective information. The mental health professional brings not only his or her technical knowledge to an assessment, but also, personal experiences and prejudices.

The purpose of the process of diagnosis and classification is to facilitate communication about the patient, across time, between professionals. Intervention cannot be implemented and its effectiveness cannot be assessed unless everyone involved in the case is speaking the same language. The DSM III is the most frequently used psychiatric diagnostic tool in the United States.

Older adults have a wide range of life styles and a wide amount of past experience to draw on. As they experience the changes that accompany the aging process, they may react and adapt to them in ways that are unique to their style of living. When they develop mental health problems, they may not present their symptoms in a traditional manner.

Review the three models of abnormal behavior that are presented in the text and have the class discuss the value of an integrated approach. Section III of the text discusses the two major tools that are used in the classification process. It is often helpful to bring a copy of the DSM III into the class.

Here are some questions that might spark a discussion in the class:

1) What is deviant?
2) What is normal?
3) Who sets the standards of normalcy?
4) Are they universal?
5) What are some examples of deviant behavior?
6) Can normal and abnormal behavior be situational? For example public nudity--is it normal behavior in a shopping mall? Is it abnormal in a nudist camp?
7) What relationship does the concept of situational normalcy have to the diagnosis of mental illness?

At some point in the session, it would be a good idea for you to go over the anatomy of the brain and the functions that it performs with the students. What I have prepared for you is a relatively simple overview of the structure of the brain and what parts of the brain perform what tasks. As I go along, I will attempt to define all of the terms that are used.

Generally, the brain's cortex (the "grey matter") can be divided into three parts. The first is the HINDBRAIN. This consists of the MEDULLA, the PONS, and the CEREBELLUM. The medulla controls important involuntary functions such as breathing, digestion, and the heartbeat. The pons serves as a "way station" for neural pathways that are on their way to other parts of the brain. The cerebellum controls our equilibrium, muscle tone, and the regulation of smoothly coordinated movements.

The second part of the brain is called the MIDBRAIN. This structure is not as important in humans as it is in the lower animals. It sends out three sets of cranial nerves to the eye muscles and is involved in the control of eye movements. Many of the neurons that use the neurotransmitter dopamine originate in this area and send their projections to the forebrain. The hindbrain and the midbrain together make up the BRAIN STEM.

Scattered throughout the brain stem is a network of cells known as the RETICULAR FORMATION (or the RETICULAR ACTIVATING SYSTEM--R.A.S.). The reticular formation plays an important role in sleep and arousal.

The FOREBRAIN is composed of two parts. The first is the DIENCEPHALON, which contains the THALAMUS, an important way station for receiving information from the various sensory organs. The information is then sent on toward the correct area in the cortex. The HYPOTHALAMUS is also contained in the diencephalon. The role of this structure is to maintain balance in many of the body's systems. For example, it controls our body temperature. It is the hypothalamus that prevents a fever from getting too high. The hypothalamus also regulates motivated behavior (ie. eating, drinking, and sexual activity) and emotional responses.

The second part of the forebrain is the CEREBRUM. Of all of the structures in the brain, it is the cerebrum that has undergone the most dramatic change in size as one travels up the evolutionary ladder. The cerebrum is composed of two heavily wrinkled halves, or hemispheres, that appear to be mirror images of each other. The two hemispheres are connected by the CORPUS CALLOSUM. Part of the cerebrum is the LIMBIC SYSTEM. This system is a grouping of structures that are responsible for the production and control of emotional responses. Lesions in one part of this area can result in an increase in fear and anger reactions. Destruction of another portion can produce an organism that is totally docile and tame.

The NEOCORTEX is the outer layer of the cerebrum and is that part of the brain that seperates humans from animals. Our neocortex is estimated to contain no less than 70% of all of the neurons in our central nervous system. Each hemisphere of the brain has a neocortex. Each of these is divided into four lobes. The lobes are seperated from each other by the CENTRAL FISSURE and the LATERAL FISSURE. The central fissure cuts across both hemispheres, over the top of the head. The lateral fissure is on the side of each hemisphere.

The cortex of the human brain is partially taken up by motor and sensory functions. Two areas that have been "mapped" via modern surgical techniques are the SOMATOSENSORY CORTEX and the MOTOR CORTEX. In these materials is a HOMUNCULUS, which is a graphic depiction of how much motor cortex is devoted to a particular body part and its movements or how much cortex is devoted to a sensory input from that body part. Tell your students to touch their fingernail lightly to their elbow. Next, have them do the same to their lower lip or their cheek. The lip and cheek areas should be much more sensitive to touch than the elbow is. Auditory information is projected to the auditory cortex, which is located just below the lateral fissure. Both hemispheres "hear" input from both ears; but, each hemisphere gets most of its information from the ear on the opposite side of the head. In other words, the right brain hears through the left ear and vise-versa. With our vision, things are a bit different and a little more complex.

Information from both eyes reaches both hemispheres. It is divided rather oddly. Light and images from the right side of each eye reach the right side of the brain and signals from the left side of each eye travel to the left side of the brain. Each optic nerve splits in two, with the two halves that are nearest to the nose going to the opposite side of the brain. The point at which they cross is the OPTIC CHIASM.

What remains of the cortex is devoted to the association areas. It is to these areas that we owe our ability to speak, read, think, and laugh. Neurons in the association areas do not receive input from the outside world; nor do they trigger any motor responses. They only talk to themselves. For most people, the language center of our brain is located on the left hemisphere. One of these areas is called BROCA'S AREA. It is located near the part of the motor cortex that controls jaw movement. Broca's Area is involved in the production of meaningful speech. Injury to this area results in aphasia. Broca's aphasia leaves a victim able to understand the speech of others and to communicate through gestures; but, they are unable to produce the spoken words that they want to use.

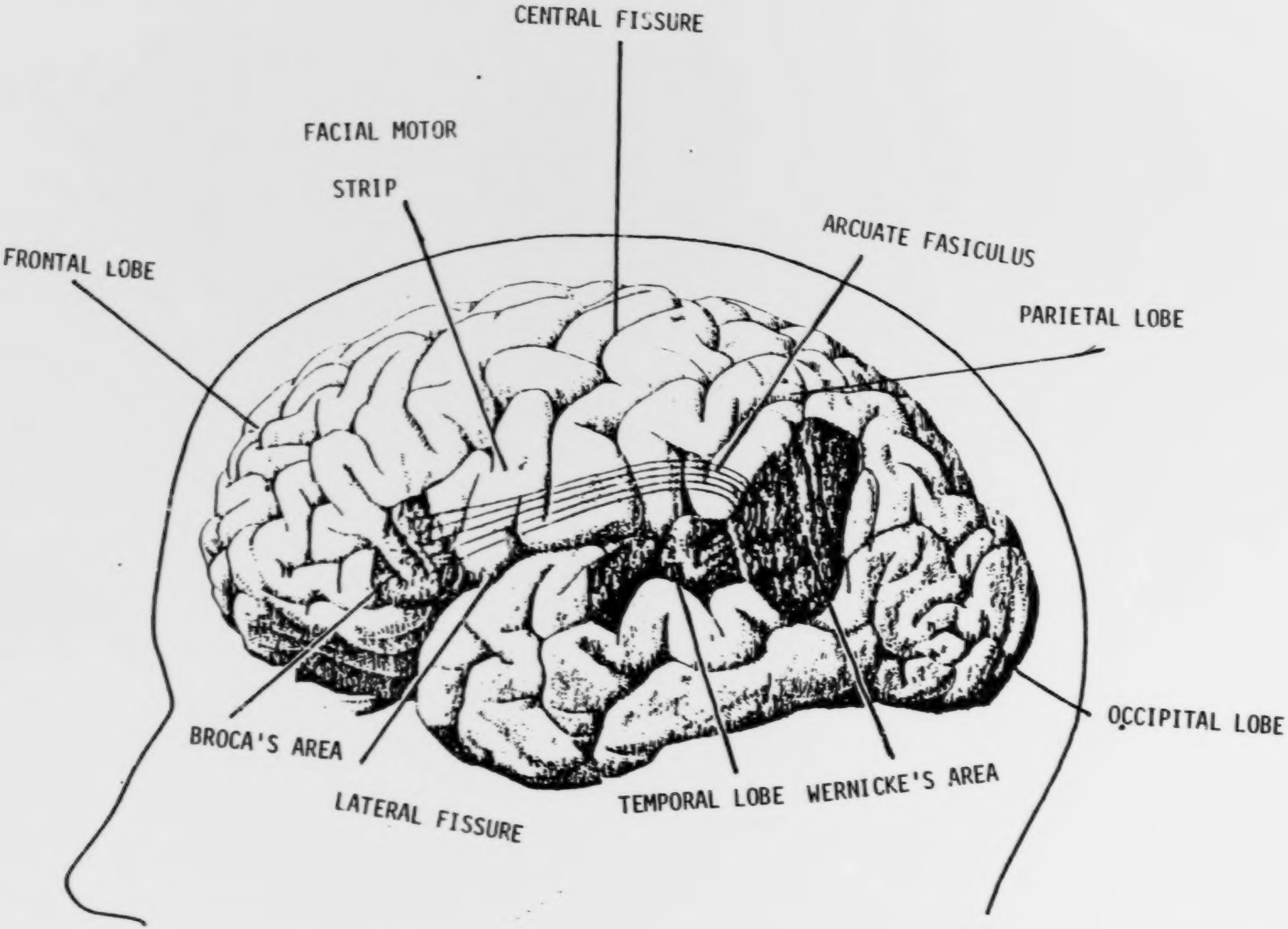
Another type of aphasia is WERNICKE'S APHASIA. In this type of aphasia, the person's comprehension and speech are affected. They will speak words fluently; but, the content of their speech is often bizarre or nonsensical.

Finally, we are going to talk a little about the right and left brain. The brain is well protected and endowed with more neurons than it needs to function. The brain is not able to grow new neurons. What we have is our lifetime supply. Small losses are not noticed. A massive injury can cause damage that is not reparable. A large injury to the left hemisphere has two usual results. One is that the person will suffer some paralysis on the right side of their body and the other is some degree of loss in their speech capability. Most people use the left side of their brain to produce speech and the right side of their body to perform tasks that require skill. Most left-handed people process speech on the left side of their brain, too, although over 13% of left-handed people produce speech on both sides of their brain.

So what do we believe is taking place on the non-speech producing hemisphere of the brain (usually, the right side)? This area of the brain seems to have a lot to do with how we perceive the emotions of others. It is the emotion behind the words that we are perceiving that allows us to know when "go to your room" means that we are in trouble. Damage to the right hemisphere interferes with the ability to "read" the emotion behind the words that we hear. Many other specialized functions are now believed to exist mainly on the right side of the brain. Some of these are the perception of melody, nonverbal patterns, and spatial relationships. In general, let us say that even though the two hemispheres perform many different functions, they perform them together. They work together on tasks and there is no sign of their different roles. Information is carried back and forth between the two sides, across a band of seperating tissue called the CORPUS CALLOSUM.

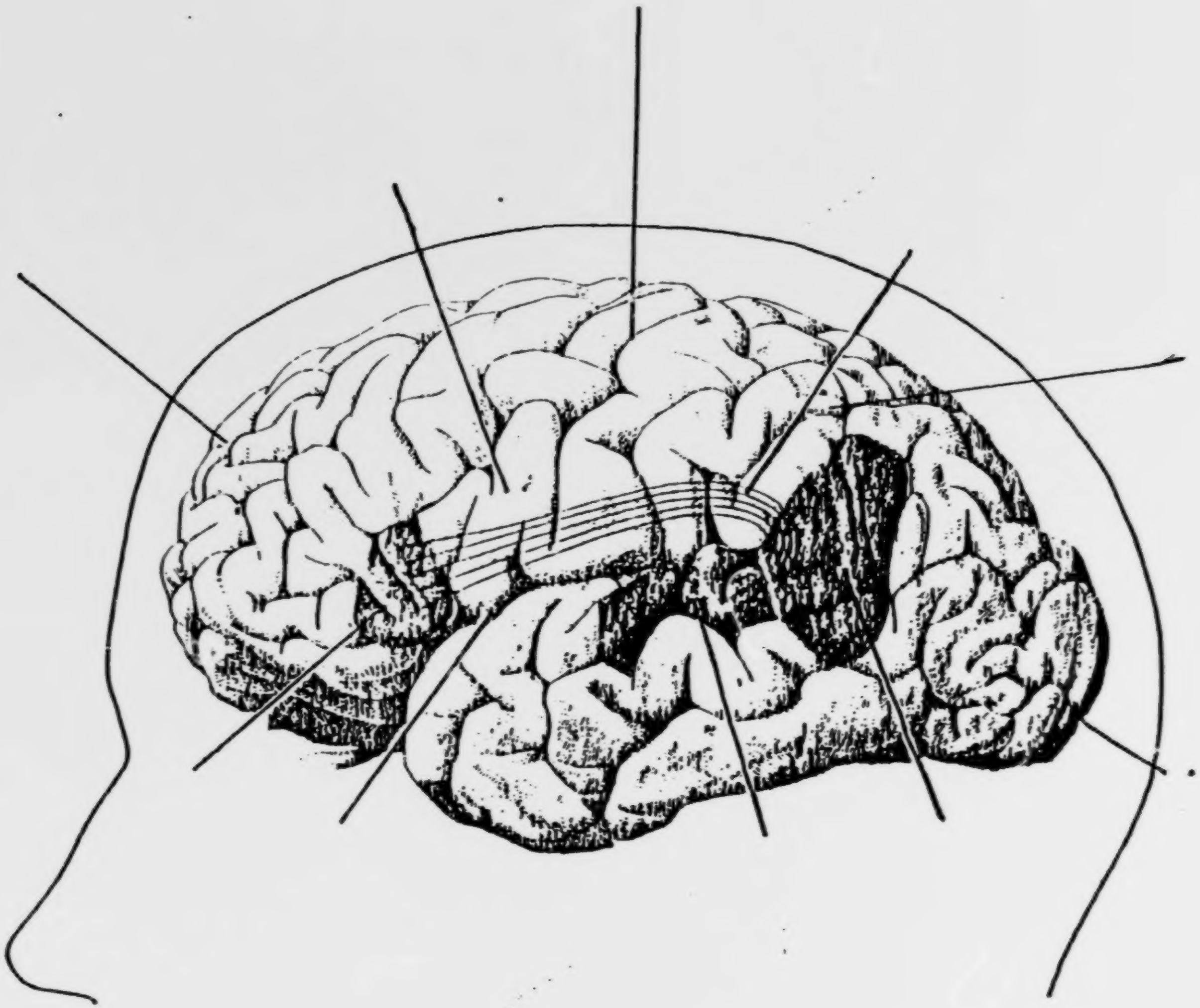
References

Darley, J.M., Glucksberg, S., Kamin, L.J., & Kinchla, R.A. (1981). Psychology, New Jersey: Prentice-Hall, Inc.

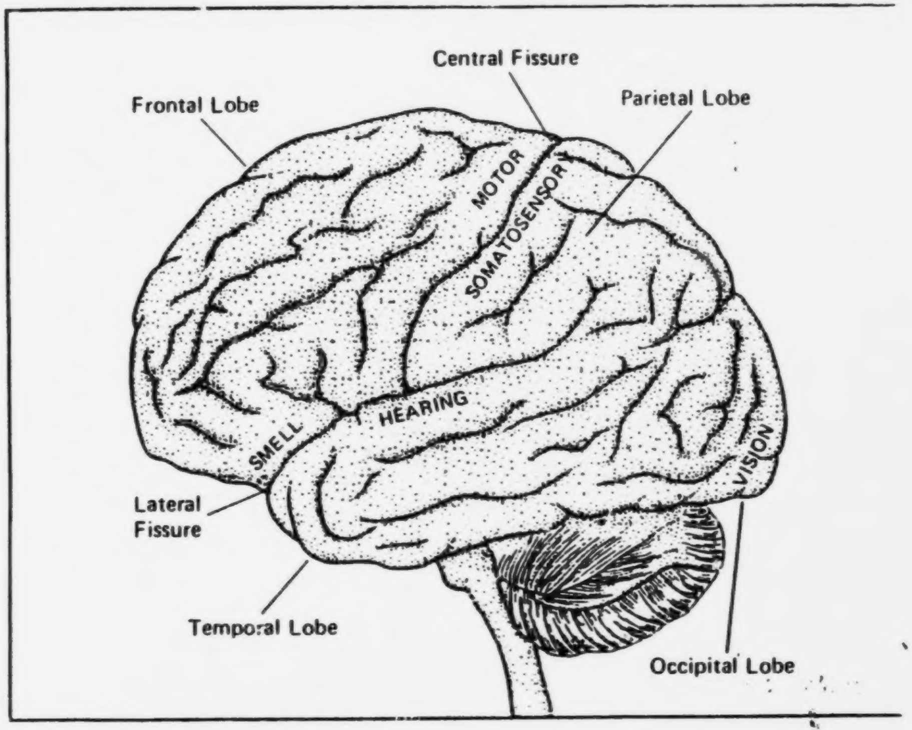


BEST COPY AVAILABLE

BLANK PAGE

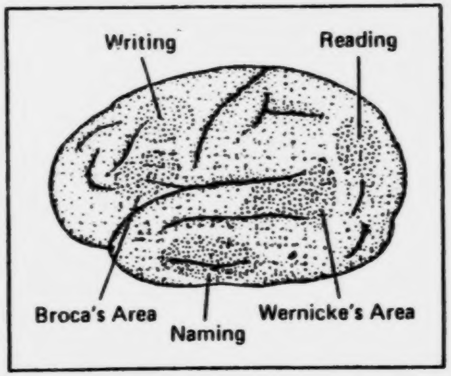


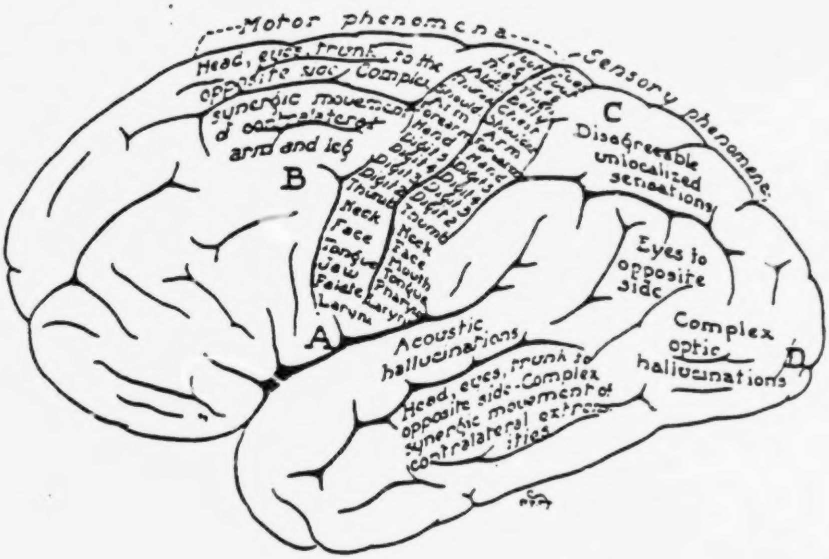
BLANK PAGE

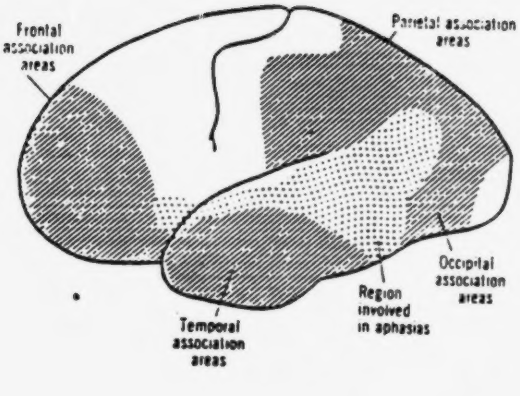


BEST COPY AVAILABLE

The usual locations of the brain areas that serve language functions are shown on the left cerebral hemisphere. The locations of these language centers vary somewhat from person to person; in some individuals they are on the right hemisphere.

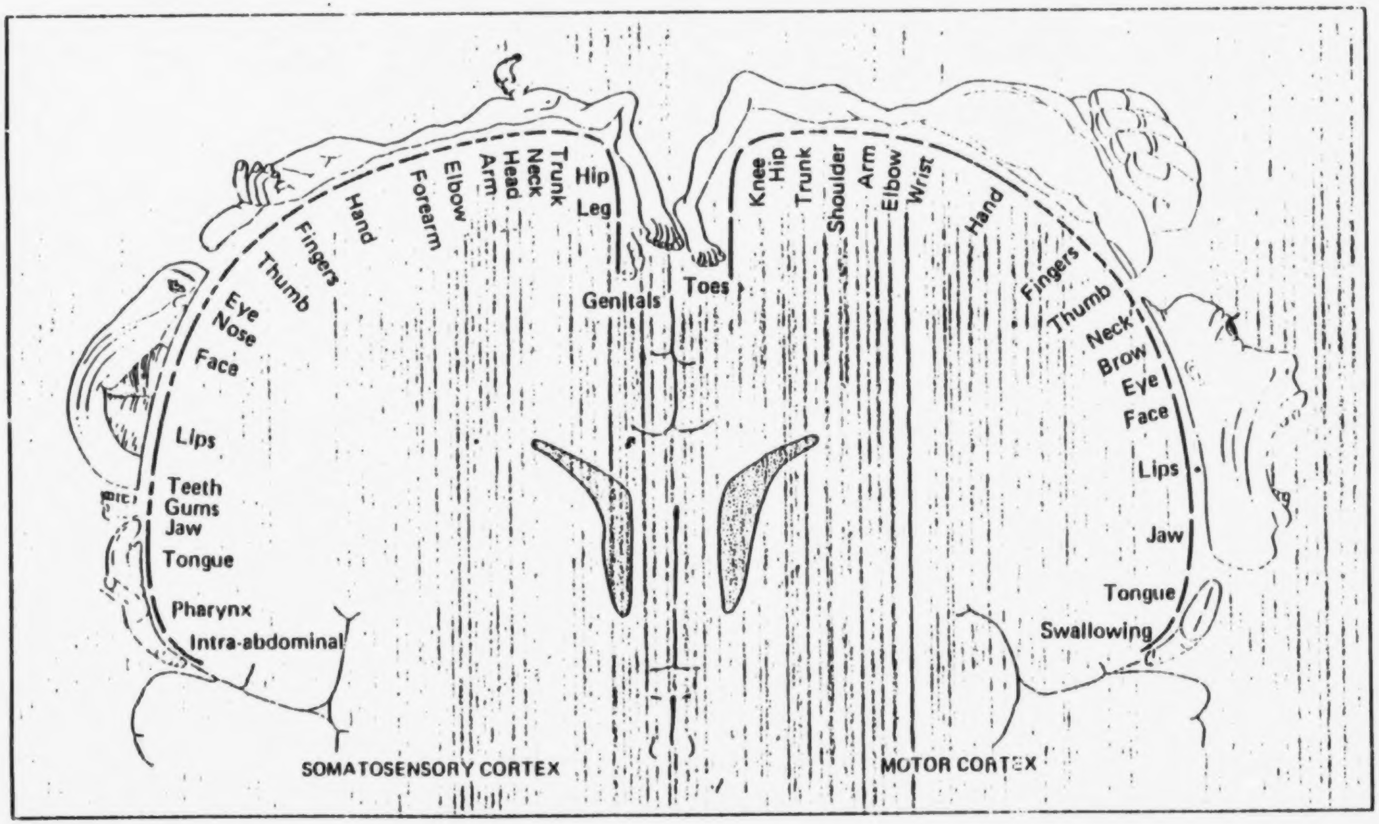




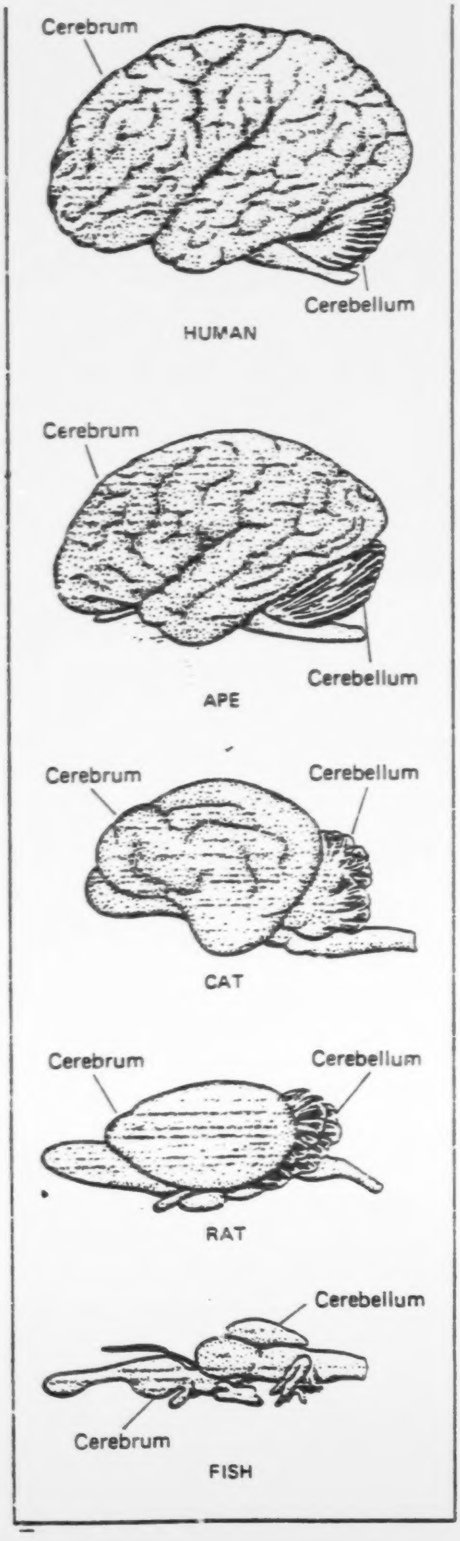

Frontal association areas
Parietal association areas
Occipital association areas
Region involved in aphasias
Temporal association areas

BEST COPY AVAILABLE

cortex, and a somatosensory homunculus. The sizes of the body parts are drawn in proportion to the amount of cortex devoted to them.
(Right) A cross-section of the motor cortex of the human cerebrum and a motor homunculus. (After Penfield and Rasmussen, 1950)



The brains of some representative vertebrates.



PSYCHOPATHOLOGY I

Name: ______________________________ Date: ____________________

CIRCLE THE CORRECT ANSWER.

1. One general indicator of abnormality is:

   a. a sense of individuality
   b. a sense of insecurity
   c. a sense of direction

2. The symptoms of mental illness are most frequently determined by:

   a. subjective information
   b. statistical data
   c. objective information

3. Changes in individual behaviors are subject to:

   a. interaction of the Ego and Superego
   b. Law of Effect
   c. Id-structure

4. The most reasonable approach to elderly psychopathology is to utilize:

   a. the Psychological Model
   b. the Integrated Model
   c. the Medical Model

5. The purpose of the process of diagnosis which is most beneficial to the client is:

   a. facilitates communication and understanding
   b. classifies illness for insurance reimbursement
   c. "labels" the individual

6. The most frequently used psychiatric diagnostic scheme currently in the United States is:

   a. ICD (International Classification of Diseases)
   b. PDR (Physician's Desk Reference)
   c. DSM-III (Diagnostic and Statistical Manual, Third Revision)

7. Most psychiatric diagnoses tend to locate the source of the problem:

   a. within the surrounding environment
   b. within the support network
   c. within the patient

8. When referring an elderly client to a mental health professional, you may expect that he/she will request:

    a. a current physical exam
    b. psychological testing
    c. a current list of medications

9. The simple common sense behavioral model is:

    a. SORCK
    b. ABC
    c. S-R

10. With the elderly, a common source of change and stress that is also crucial to maintaining general health and well-being is:

    a. ego strength
    b. social network
    c. caring family members

Psychopathology I

1. b
2. a
3. b
4. b
5. a
6. c
7. c
8. a
9. b
10. b

BLANK PAGE

Decision Trees For Differential Diagnosis*

The purpose of these decision trees is to aid the clinician in understanding the organization and hierarchical structure of the classification. Each decision tree starts with a set of clinical features. When one of these features is a prominent part of the presenting clinical picture, the clinician can follow the series of questions to rule in or out various diagnostic categories. The questions are only approximations of the actual diagnostic criteria. The decision trees are not meant to replace the specific diagnostic criteria.

Page

Psychotic features 200

Irrational anxiety and avoidance behavior 204

Mood disturbance (depressed, irritable or expansive) 202

Antisocial, aggressive, defiant, or oppositional behavior 205

Physical complaints and irrational anxiety about physical illness 206

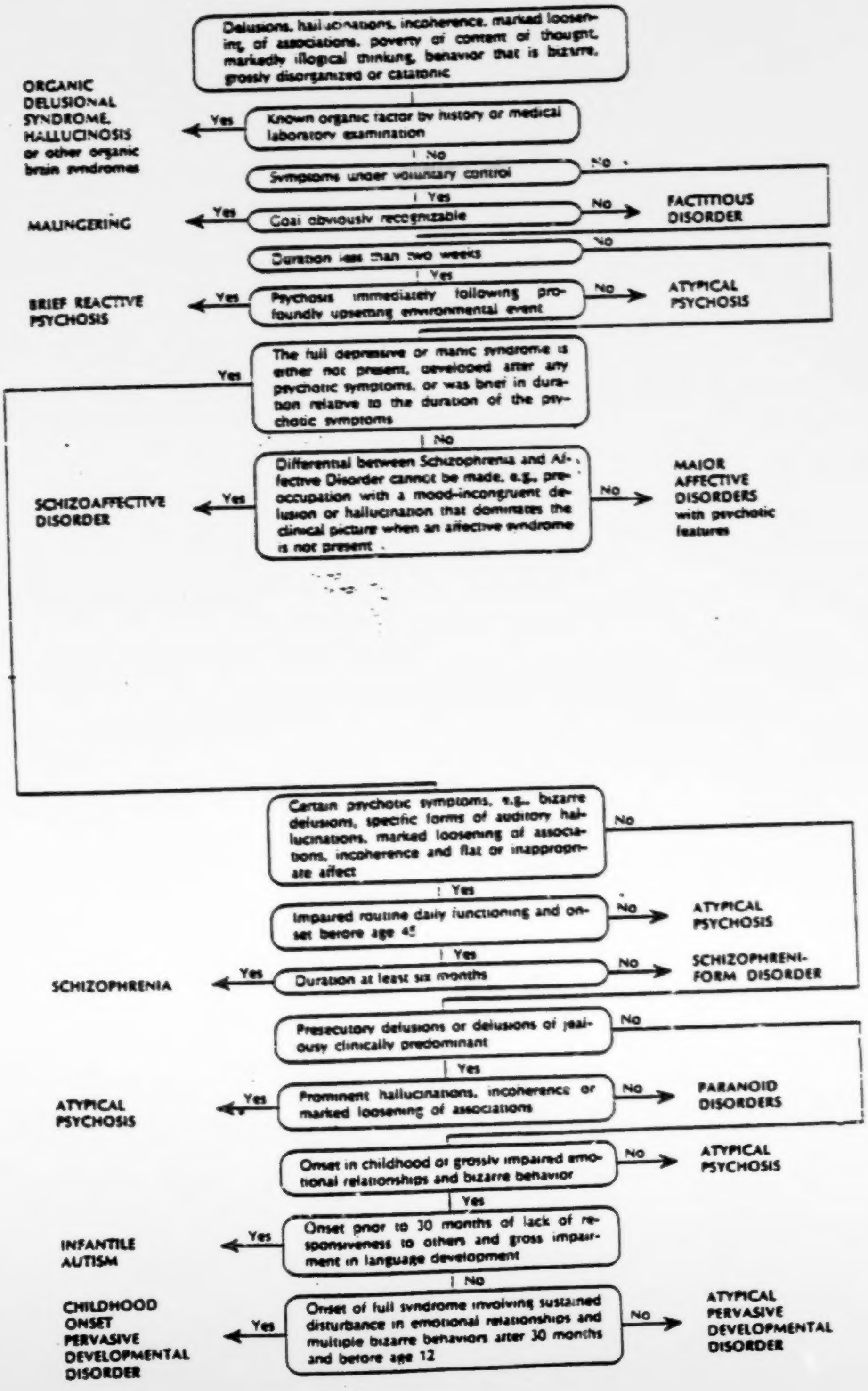
Academic or learning difficulties 208

Organic Brain Syndromes 209

---

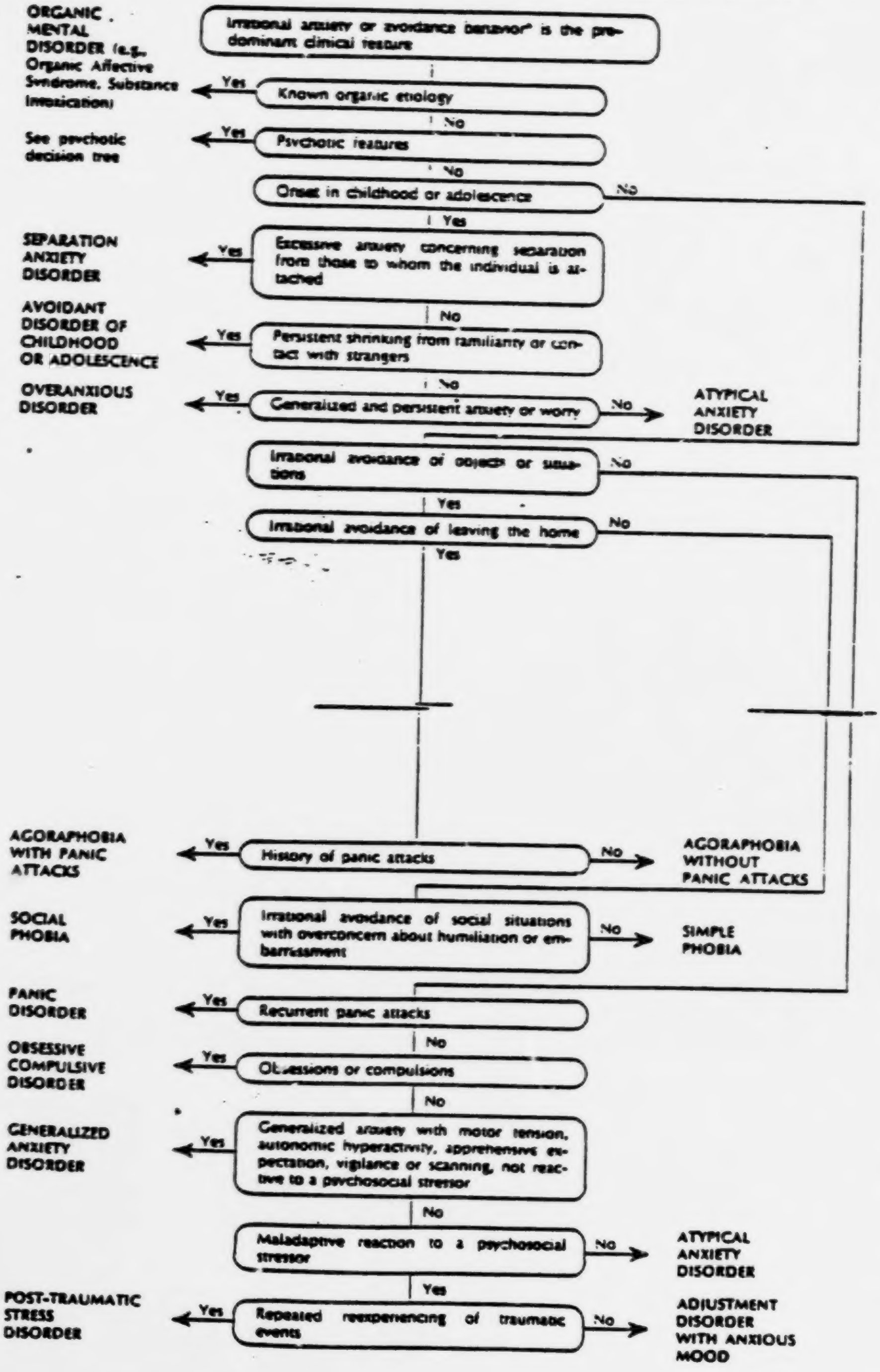
* Prepared by Robert L. Spitzer, M.D. and Janet B.W. Williams, M.S.W.

DIFFERENTIAL DIAGNOSIS OF PSYCHOTIC FEATURES



Delusions, hallucinations, incoherence, marked loosening of associations, poverty of content of thought, markedly illogical thinking, behavior that is bizarre, grossly disorganized or catatonic
Known organic factor by history or medical laboratory examination
Yes
ORGANIC DELUSIONAL SYNDROME, HALLUCINOSIS or other organic brain syndromes
No
Symptoms under voluntary control
No
Yes
Goal obviously recognizable
Yes
MALINGERING
No
FACTITIOUS DISORDER
No
Duration less than two weeks
Yes
Psychosis immediately following profoundly upsetting environmental event
Yes
BRIEF REACTIVE PSYCHOSIS
No
ATYPICAL PSYCHOSIS
The full depressive or manic syndrome is either not present, developed after any psychotic symptoms, or was brief in duration relative to the duration of the psychotic symptoms
Yes
No
Differential between Schizophrenia and Affective Disorder cannot be made, e.g., preoccupation with a mood-incongruent delusion or hallucination that dominates the clinical picture when an affective syndrome is not present
Yes
SCHIZOAFFECTIVE DISORDER
No
MAJOR AFFECTIVE DISORDERS with psychotic features
Certain psychotic symptoms, e.g., bizarre delusions, specific forms of auditory hallucinations, marked loosening of associations, incoherence and flat or inappropriate affect
No
Yes
Impaired routine daily functioning and onset before age 45
No
ATYPICAL PSYCHOSIS
Yes
Duration at least six months
Yes
SCHIZOPHRENIA
No
SCHIZOPHRENIFORM DISORDER
Presecutory delusions or delusions of jealousy clinically predominant
No
Yes
Prominent hallucinations, incoherence or marked loosening of associations
Yes
ATYPICAL PSYCHOSIS
No
PARANOID DISORDERS
Onset in childhood or grossly impaired emotional relationships and bizarre behavior
No
ATYPICAL PSYCHOSIS
Yes
Onset prior to 30 months of lack of responsiveness to others and gross impairment in language development
Yes
INFANTILE AUTISM
No
Onset of full syndrome involving sustained disturbance in emotional relationships and multiple bizarre behaviors after 30 months and before age 12
Yes
CHILDHOOD ONSET PERVASIVE DEVELOPMENTAL DISORDER
No
ATYPICAL PERVASIVE DEVELOPMENTAL DISORDER

DIFFERENTIAL DIAGNOSIS OF IRRATIONAL ANXIETY AND AVOIDANCE BEHAVIOR

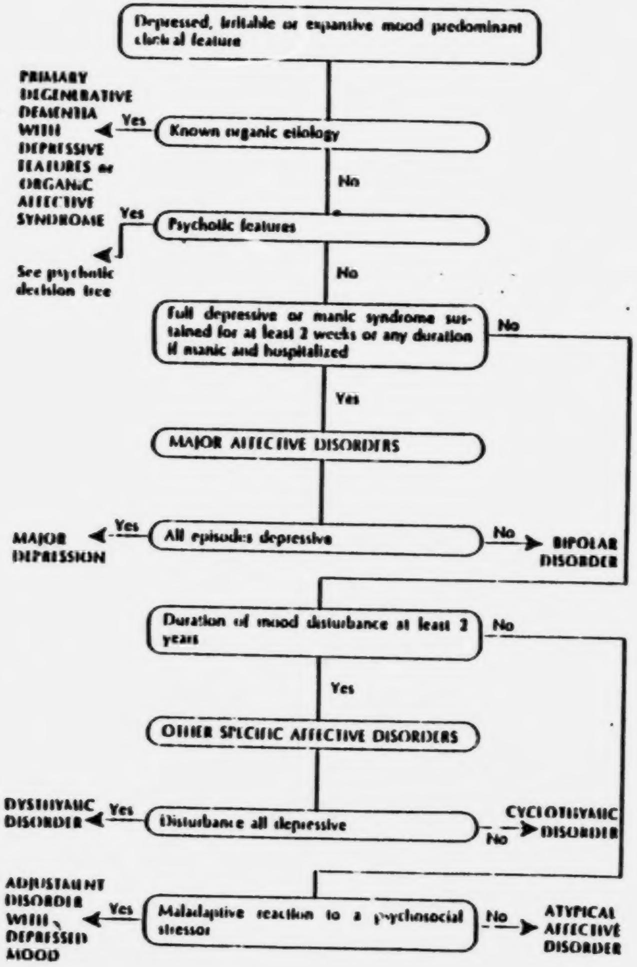

Irrational anxiety or avoidance behavior* is the predominant clinical feature
ORGANIC MENTAL DISORDER (e.g., Organic Affective Syndrome, Substance Intoxication)
Yes
Known organic etiology
No
See psychotic decision tree
Yes
Psychotic features
No
Onset in childhood or adolescence
No
Yes
SEPARATION ANXIETY DISORDER
Yes
Excessive anxiety concerning separation from those to whom the individual is attached
No
AVOIDANT DISORDER OF CHILDHOOD OR ADOLESCENCE
Yes
Persistent shrinking from familiarity or contact with strangers
No
OVERANXIOUS DISORDER
Yes
Generalized and persistent anxiety or worry
No
ATYPICAL ANXIETY DISORDER
Irrational avoidance of objects or situations
No
Yes
Irrational avoidance of leaving the home
No
Yes
AGORAPHOBIA WITH PANIC ATTACKS
Yes
History of panic attacks
No
AGORAPHOBIA WITHOUT PANIC ATTACKS
SOCIAL PHOBIA
Yes
Irrational avoidance of social situations with overconcern about humiliation or embarrassment
No
SIMPLE PHOBIA
PANIC DISORDER
Yes
Recurrent panic attacks
No
OBSESSIVE COMPULSIVE DISORDER
Yes
Obsessions or compulsions
No
GENERALIZED ANXIETY DISORDER
Yes
Generalized anxiety with motor tension, autonomic hyperactivity, apprehensive expectation, vigilance or scanning, not reactive to a psychosocial stressor
No
Maladaptive reaction to a psychosocial stressor
No
ATYPICAL ANXIETY DISORDER
Yes
POST-TRAUMATIC STRESS DISORDER
Yes
Repeated reexperiencing of traumatic events
No
ADJUSTMENT DISORDER WITH ANXIOUS MOOD

---

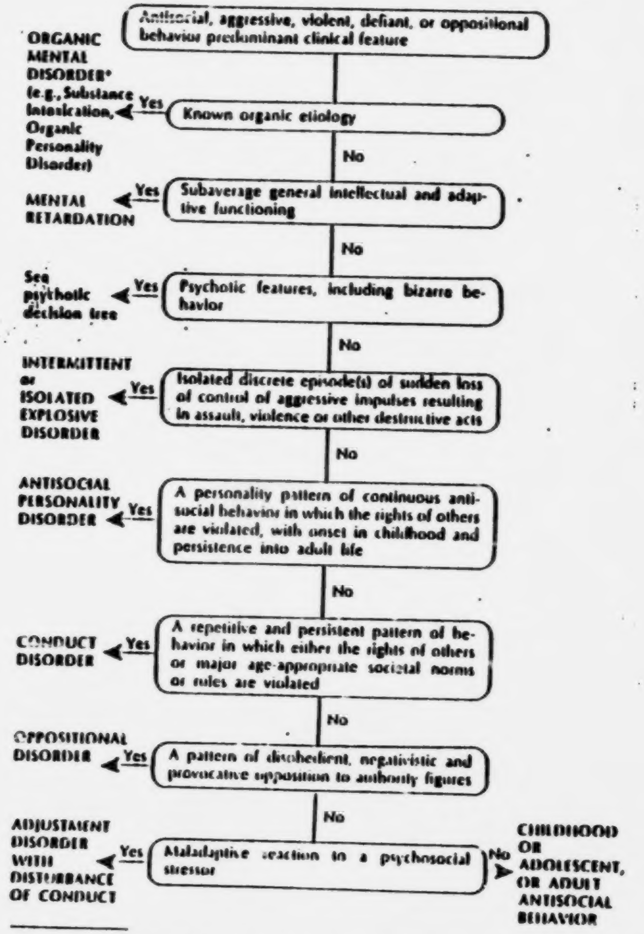
* Also consider Personality Disorders (Axis II), such as Avoidant, Borderline, Compulsive, and Schizotypal Personality Disorders.

BEST COPY AVAILABLE

DIFFERENTIAL DIAGNOSIS OF MOOD DISTURBANCE


Depressed, irritable or expansive mood predominant clinical feature
PRIMARY DEGENERATIVE DEMENTIA WITH DEPRESSIVE FEATURES or ORGANIC AFFECTIVE SYNDROME
Yes
Known organic etiology
No
Yes
Psychotic features
See psychotic decision tree
No
Full depressive or manic syndrome sustained for at least 2 weeks or any duration if manic and hospitalized
No
Yes
MAJOR AFFECTIVE DISORDERS
MAJOR DEPRESSION
Yes
All episodes depressive
No
BIPOLAR DISORDER
Duration of mood disturbance at least 2 years
No
Yes
OTHER SPECIFIC AFFECTIVE DISORDERS
DYSTHYMIC DISORDER
Yes
Disturbance all depressive
No
CYCLOTHYMIC DISORDER
ADJUSTMENT DISORDER WITH DEPRESSED MOOD
Yes
Maladaptive reaction to a psychosocial stressor
No
ATYPICAL AFFECTIVE DISORDER

DIFFERENTIAL DIAGNOSIS OF ANTISOCIAL, AGGRESSIVE, DEFIANT, OR OPPOSITIONAL BEHAVIOR

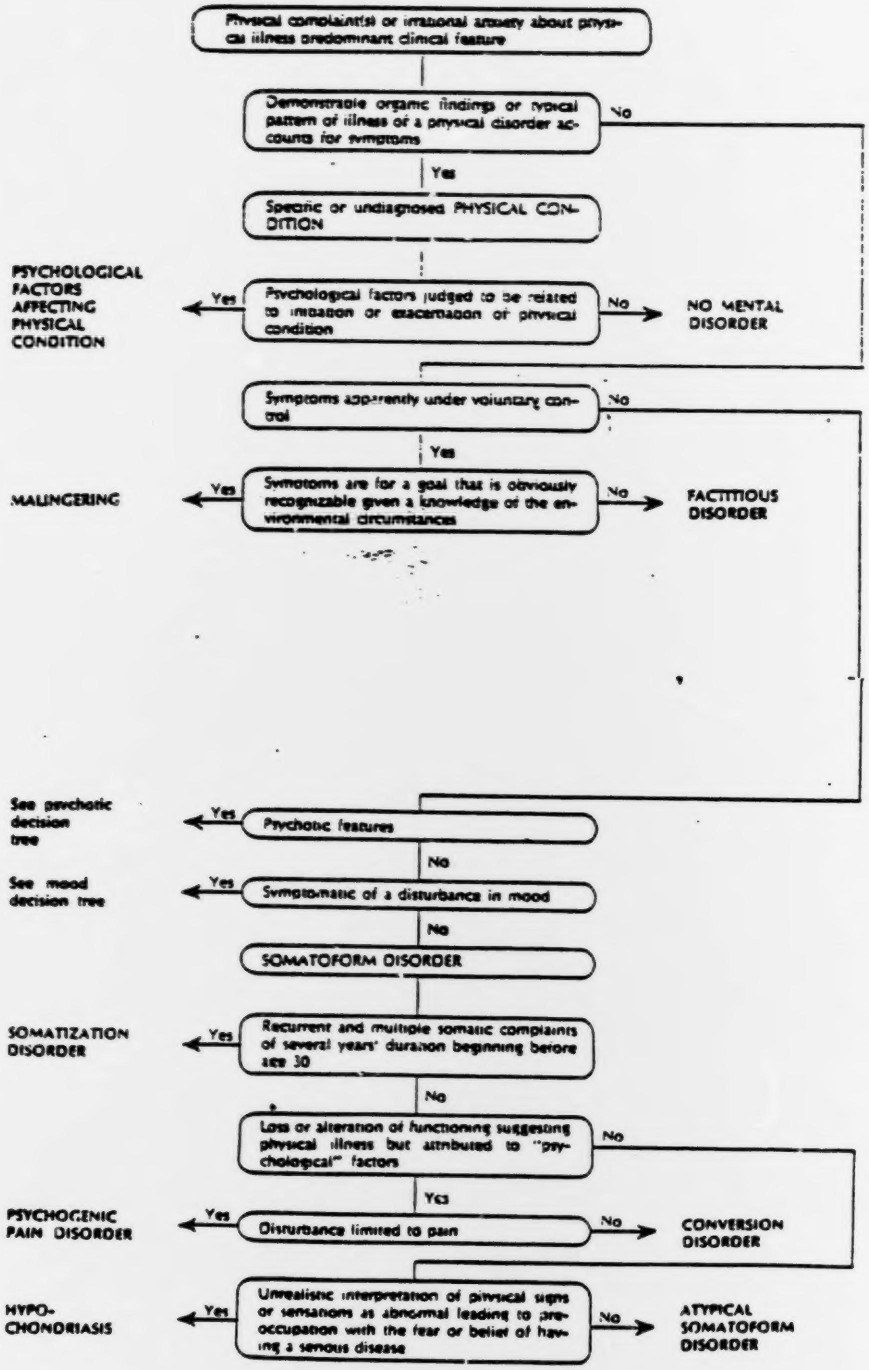

Antisocial, aggressive, violent, defiant, or oppositional behavior predominant clinical feature
ORGANIC MENTAL DISORDER* (e.g., Substance Intoxication, Organic Personality Disorder)
Yes
Known organic etiology
No
MENTAL RETARDATION
Yes
Subaverage general intellectual and adaptive functioning
No
See psychotic decision tree
Yes
Psychotic features, including bizarre behavior
No
INTERMITTENT or ISOLATED EXPLOSIVE DISORDER
Yes
Isolated discrete episode(s) of sudden loss of control of aggressive impulses resulting in assault, violence or other destructive acts
No
ANTISOCIAL PERSONALITY DISORDER
Yes
A personality pattern of continuous antisocial behavior in which the rights of others are violated, with onset in childhood and persistence into adult life
No
CONDUCT DISORDER
Yes
A repetitive and persistent pattern of behavior in which either the rights of others or major age-appropriate societal norms or rules are violated
No
OPPOSITIONAL DISORDER
Yes
A pattern of disobedient, negativistic and provocative opposition to authority figures
No
ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT
Yes
Maladaptive reaction to a psychosocial stressor
No
CHILDHOOD OR ADOLESCENT, OR ADULT ANTISOCIAL BEHAVIOR

---

* Also consider Intermittent Explosive Disorder which can be diagnosed when symptomatic of an Organic Mental Disorder

BEST COPY AVAILABLE

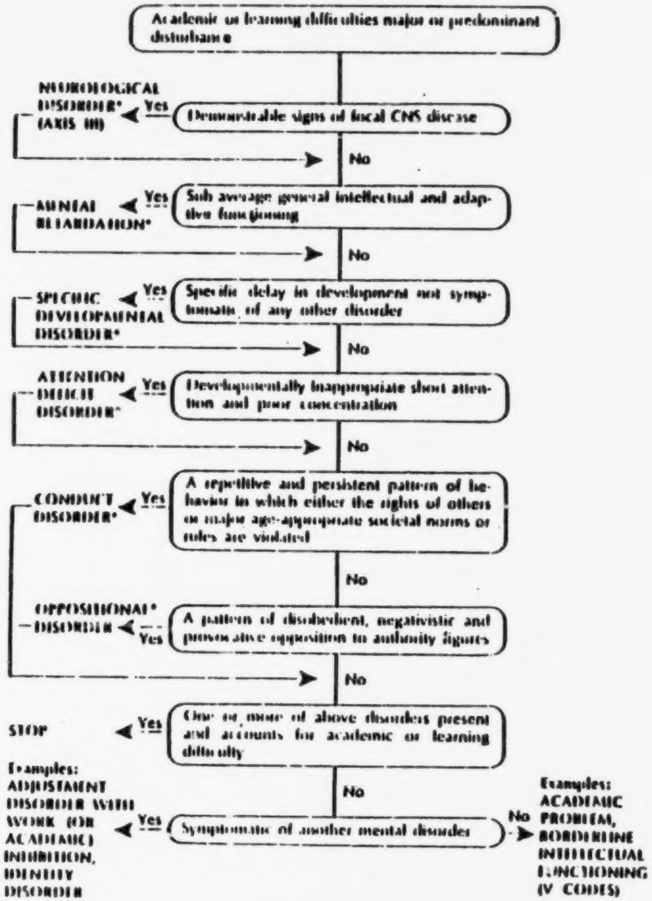
DIFFERENTIAL DIAGNOSIS OF PHYSICAL COMPLAINTS
AND IRRATIONAL ANXIETY ABOUT PHYSICAL ILLNESS



Physical complaint(s) or irrational anxiety about physical illness predominant clinical feature
Demonstrable organic findings or typical pattern of illness of a physical disorder accounts for symptoms
No
Yes
Specific or undiagnosed PHYSICAL CONDITION
PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION
Yes
Psychological factors judged to be related to initiation or exacerbation of physical condition
No
NO MENTAL DISORDER
Symptoms apparently under voluntary control
No
Yes
MALINGERING
Yes
Symptoms are for a goal that is obviously recognizable given a knowledge of the environmental circumstances
No
FACTITIOUS DISORDER
See psychotic decision tree
Yes
Psychotic features
No
See mood decision tree
Yes
Symptomatic of a disturbance in mood
No
SOMATOFORM DISORDER
SOMATIZATION DISORDER
Yes
Recurrent and multiple somatic complaints of several years' duration beginning before age 30
No
Loss or alteration of functioning suggesting physical illness but attributed to "psychological" factors
No
Yes
PSYCHOGENIC PAIN DISORDER
Yes
Disturbance limited to pain
No
CONVERSION DISORDER
HYPOCHONDRIASIS
Yes
Unrealistic interpretation of physical signs or sensations as abnormal leading to preoccupation with the fear or belief of having a serious disease
No
ATYPICAL SOMATOFORM DISORDER

BEST COPY AVAILABLE

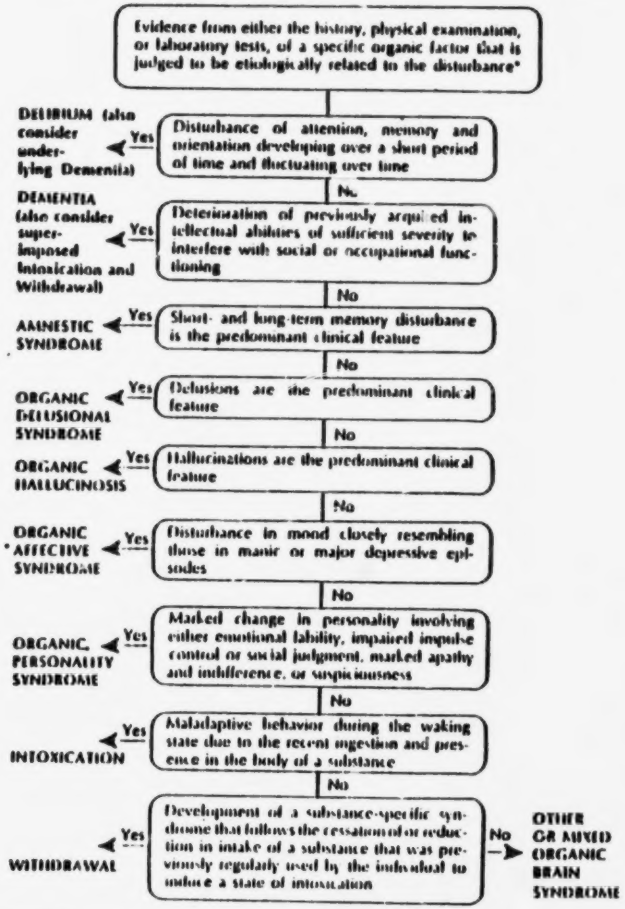
DIFFERENTIAL DIAGNOSIS OF ACADEMIC OR LEARNING DIFFICULTIES


Academic or learning difficulties major or predominant disturbance
NEUROLOGICAL DISORDER* (AXIS III)
Yes
Demonstrable signs of focal CNS disease
No
MENTAL RETARDATION*
Yes
Sub average general intellectual and adaptive functioning
No
SPECIFIC DEVELOPMENTAL DISORDER*
Yes
Specific delay in development not symptomatic of any other disorder
No
ATTENTION DEFICIT DISORDER*
Yes
Developmentally inappropriate short attention and poor concentration
No
CONDUCT DISORDER*
Yes
A repetitive and persistent pattern of behavior in which either the rights of others or major age-appropriate societal norms or rules are violated
No
OPPOSITIONAL* DISORDER
Yes
A pattern of disobedient, negativistic and provocative opposition to authority figures
No
STOP
Yes
One or more of above disorders present and accounts for academic or learning difficulty
No
Examples: ADJUSTMENT DISORDER WITH WORK (OR ACADEMIC) INHIBITION, IDENTITY DISORDER
Yes
Symptomatic of another mental disorder
No
Examples: ACADEMIC PROBLEM, BORDERLINE INTELLECTUAL FUNCTIONING (V CODES)

---

* The arrows returning to the trunk of the tree indicate the possibility of multiple diagnoses.

DIFFERENTIAL DIAGNOSIS OF ORGANIC BRAIN SYNDROMES


Evidence from either the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance*
DELIRIUM (also consider underlying Dementia)
Yes
Disturbance of attention, memory and orientation developing over a short period of time and fluctuating over time
No
DEMENTIA (also consider superimposed Intoxication and Withdrawal)
Yes
Deterioration of previously acquired intellectual abilities of sufficient severity to interfere with social or occupational functioning
No
AMNESTIC SYNDROME
Yes
Short- and long-term memory disturbance is the predominant clinical feature
No
ORGANIC DELUSIONAL SYNDROME
Yes
Delusions are the predominant clinical feature
No
ORGANIC HALLUCINOSIS
Yes
Hallucinations are the predominant clinical feature
No
ORGANIC AFFECTIVE SYNDROME
Yes
Disturbance in mood closely resembling those in manic or major depressive episodes
No
ORGANIC PERSONALITY SYNDROME
Yes
Marked change in personality involving either emotional lability, impaired impulse control or social judgment, marked apathy and indifference, or suspiciousness
No
INTOXICATION
Yes
Maladaptive behavior during the waking state due to the recent ingestion and presence in the body of a substance
No
WITHDRAWAL
Yes
Development of a substance-specific syndrome that follows the cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a state of intoxication
No
OTHER OR MIXED ORGANIC BRAIN SYNDROME

---

* In the absence of such evidence, an organic factor can be presumed if conditions outside of the Organic Mental Disorders category have been reasonably excluded and if the disturbance meets the symptomatic criteria for Dementia

Use of This Manual

MULTIAXIAL EVALUATION

A multiaxial evaluation requires that every case be assessed on each of several "axes," each of which refers to a different class of information. In order for the system to have maximal clinical usefulness, there must be a limited number of axes; there are five in the DSM-III multiaxial classification. The first three axes constitute the official diagnostic assessment.

Each individual is evaluated on each of these axes:

Axis I	Clinical Syndromes Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment (V. Codes) Additional Codes
Axis II	Personality Disorders Specific Developmental Disorders
Axis III	Physical Disorders and Conditions

Axes IV and V are available for use in special clinical and research settings and provide information supplementing the official DSM-III diagnoses (Axes I, II, and III) that may be useful for planning treatment and predicting outcome:

Axis IV	Severity of Psychosocial Stressors
Axis V	Highest Level of Adaptive Functioning Past Year

Use of the DSM-III multiaxial classification ensures that attention is given to certain types of disorders, aspects of the environment, and areas of functioning that might be overlooked if the focus were on assessing a single presenting problem.

Axes I and II

Axes I and II comprise the entire classification of mental disorders plus Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment. The disorders listed on Axis II are the Personality Disorders (for adults and, in some cases, for children and adolescents) and the Specific Developmental Disorders (for children and adolescents and, in some cases, for adults). The remaining disorders and conditions are included in Axis I. This separation ensures that consideration is given to the possible presence of disorders that are frequently overlooked when attention is directed to the usually more florid Axis I disorder.

In some instances an individual may have a disorder on both axes. For example, an adult may have Major Depression noted on Axis I and Compulsive Personality Disorder on Axis II, or a child may have Conduct Disorder noted on Axis I and Developmental Language Disorder on Axis II. In other instances there may be no disorder on Axis I, the reason for seeking treatment being limited to a condition noted on Axis II. In this latter case, the clinician should write: *Axis I:* V71.09 No diagnosis or condition on Axis I. On the other hand, if a disorder is noted on Axis I but there is no evidence of an Axis II disorder, the clinician should write: *Axis II:* V71.09 No diagnosis on Axis II, or one of the Conditions Not Attributable to a Mental Disorder should be recorded.

Multiple diagnoses within Axes I and II

On both Axes I and II, multiple diagnoses should be made when necessary to describe the current condition. This applies particularly to Axis I, in which, for example, an individual may have both a Substance Use Disorder and an Affective Disorder. It is possible to have multiple diagnoses within the same class. For example, it is possible to have several Substance Use Disorders or, in the class of Affective Disorders, it is possible to have Major Depression superimposed on Dysthymic Disorder or Bipolar Disorder superimposed on Cyclothymic Disorder. In other classes, such as Schizophrenic Disorders, however, each of the subtypes is mutually exclusive.

Within Axis II, the diagnosis of multiple Specific Developmental Disorders is common. For some adults the persistence of a Specific Developmental Disorder and the presence of a Personality Disorder may require that both be noted on Axis II. Usually, a single Personality Disorder will be noted; but when the individual meets the criteria for more than one, all should be recorded.

Axis II and description of personality features

Axis II can be used to indicate specific personality traits when no Personality Disorder exists. For example, compulsive traits can be recorded on Axis II for an individual for whom Major Depression is noted on Axis I. Even when a Personality Disorder is noted on Axis II, the clinician may wish to indicate other personality characteristics—e.g., paranoid traits can be noted on Axis II for an individual who is also described as having Compulsive Personality Disorder on this same axis. (Code numbers should not be used when personality *traits* are noted, since a code number indicates a Personality *Disorder*.)

Principal diagnosis

When an individual receives more than one diagnosis, the *principal* diagnosis is the condition that was chiefly responsible for occasioning the evaluation or admission to clinical care. In most cases this condition will be the main focus of attention or treatment. The principal diagnosis may be an Axis I or an Axis II diagnosis; but when an Axis II diagnosis is the principal diagnosis the notation should be followed by the phrase "(Principal diagnosis)."

Example:	Axis I:	303.93	Alcohol Dependence, In Remission
	Axis II:	301.70	Antisocial Personality Disorder (Principal diagnosis)

When an individual has both an Axis I and an Axis II diagnosis, the principal diagnosis will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal diagnosis)."

When multiple diagnoses are made on either Axis I or Axis II, they should be listed within each axis in the order of focus of attention or treatment. For example, if an individual with Schizophrenia, Paranoid Type, Chronic, comes to an emergency room for treatment of Alcohol Intoxication, the diagnosis should be listed:

Axis I:	303.00	Alcohol Intoxication
	295.32	Schizophrenia, Paranoid Type, Chronic

Provisional diagnosis

In some instances not enough information will be available to make a firm diagnosis. The clinician may wish to indicate a significant degree of diagnostic uncertainty by writing "(Provisional)" following the diagnosis—e.g., Schizophreniform Disorder (Provisional, rule out Organic Delusional Syndrome).

Levels of diagnostic certainty

Frequently a diagnostic evaluation yields insufficient information to make a specific diagnosis. The following table indicates the various ways in which a clinician may indicate diagnostic uncertainty:

Term	Examples of clinical situations
V Codes (for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment)	Insufficient information to know whether or not a presenting problem is attributable to a mental disorder, e.g., Academic Problem; Adult Antisocial Behavior.
799.90 Diagnosis or Condition Deferred on Axis I	Information inadequate to make any diagnostic judgment about an Axis I diagnosis or condition.
799.90 Diagnosis Deferred on Axis II	Same for an Axis II diagnosis.
300.90 Unspecified Mental Disorder (non-psychotic)	Enough information available to rule out a psychotic disorder, but further specification is not possible.
298.90 Atypical Psychosis	Enough information available to determine the presence of a psychotic disorder, but further specification is not possible.

BEST COPY AVAILABLE

Term	Examples of clinical situations
Atypical (class of disorder)	Enough information available to indicate the class of disorder that is present, but further specification is not possible, because either there is not sufficient information to make a more specific diagnosis, or the clinical features of the disorder do not meet the criteria for any of the other categories, e.g., Atypical Affective Disorder.
Specific diagnosis (Provisional)	Enough information available to make a "working" diagnosis, but the clinician wishes to indicate a significant degree of diagnostic uncertainty, e.g., Schizophreniform Disorder (Provisional).

Axis III. Physical Disorders or Conditions

Axis III permits the clinician to indicate any current physical disorder or condition that is potentially relevant to the understanding or management of the individual. These are the conditions outside of the mental disorders section of ICD-9-CM. In some instances the condition may be etiologically significant (e.g., a neurologic disorder associated with Dementia); in other instances the physical disorder may not be etiologic, but important in the overall management of the individual (e.g., diabetes in a child with a Conduct Disorder). In yet other instances, the clinician may wish to note significant associated physical findings, such as "soft neurological signs." Multiple diagnoses are permitted.

Axis IV. Severity of Psychosocial Stressors

Axis IV provides a coding of the overall severity of a stressor judged to have been a significant contributor to the development or exacerbation of the current disorder. An individual's prognosis may be better when a disorder develops as a consequence of a severe stressor than when it develops after no stressor or a minimal stressor.

Rating the severity of the stressor. This rating should be based on the clinician's assessment of the stress an "average" person in similar circumstances and with similar sociocultural values would experience from the particular psychosocial stressor(s). This judgment involves consideration of the following: the amount of change in the individual's life caused by the stressor, the degree to which the event is desired and under the individual's control, and the number of stressors. Even though a specific stressor may have greater impact on an individual who is especially vulnerable or has certain internal conflicts, the rating should be based on the severity of the stressor itself, not on the individual's vulnerability to the particular stressor. If a vulnerability to stress exists, it will frequently be due to a mental disorder that is coded on Axis I or II.

In most instances the psychosocial stressor will have occurred within a year prior to the current disorder (Post-traumatic Stress Disorder is a notable exception). In some instances the stressor is the anticipation of a future event: for example, the knowledge that one will soon retire. Although a stressor frequently plays a precipitating role in a disorder, it may also be a consequence of the individual's psychopathology—e.g., Alcohol Dependence may lead to marital problems and divorce, which can then become stressors contributing to the development of a Major Depression. The current disorder that is related to the psychosocial stressor may be either a clinical syndrome, coded on Axis I, or an exacerbation of a Personality or Specific Developmental Disorder, coded on Axis II.

In addition to the severity rating, in certain settings it may be useful to note the specific psychosocial stressor (e.g., chronic marital discord about sharing household duties). This information may be important in formulating a treatment plan that includes attempts to remove the psychosocial stressor or to help the individual cope with it. More than one psychosocial stressor may be judged etiologically significant by the clinician, but rarely will more than four be recorded. The stressors should be noted as specifically as possible and listed in order of their importance.

The severity rating should reflect the summed effect of all of the psychosocial stressors that are listed. The following codes and terms may be used as guides in making the rating:

Code	Term	Adult examples	Child or adolescent examples
1	None	No apparent psychosocial stressor	No apparent psychosocial stressor
2	Minimal	Minor violation of the law; small bank loan	Vacation with family
3	Mild	Argument with neighbor; change in work hours	Change in schoolteacher; new school year
4	Moderate	New career; death of close friend; pregnancy	Chronic parental fighting; change to new school; illness of close relative; birth of sibling
5	Severe	Serious illness in self or family; major financial loss; marital separation; birth of child	Death of peer; divorce of parents; arrest; hospitalization; persistent and harsh parental discipline
6	Extreme	Death of close relative; divorce	Death of parent or sibling; repeated physical or sexual abuse
7	Catastrophic	Concentration camp experience; devastating natural disaster	Multiple family deaths
0	Unspecified	No information, or not applicable	No information, or not applicable

Types of psychosocial stressors to be considered. To ascertain etiologically significant psychosocial stressors, the following areas may be considered:

Conjugal (marital and nonmarital): e.g., engagement, marriage, discord, separation, death of spouse.

Parenting: e.g., becoming a parent, friction with child, illness of child.

Other interpersonal: problems with one's friends, neighbors, associates, or nonconjugal family members, e.g., illness of best friend, discordant relationship with boss.

Occupational: includes work, school, homemaker, e.g., unemployment, retirement, school problems.

Living circumstances: e.g., change in residence, threat to personal safety, immigration.

Financial: e.g., inadequate finances, change in financial status.

Legal: e.g., arrested, jailed, lawsuit or trial.

Developmental: phases of the life cycle, e.g., puberty, transition to adult status, menopause, "becoming 50."

Physical illness or injury: e.g., illness, accident, surgery, abortion. (*Note:* A physical disorder is listed on Axis III whenever it is related to the development or management of an Axis I or II disorder. A physical disorder can also be a psychosocial stressor if its impact is due to its meaning to the individual, in which case it would be listed on both Axis III and Axis IV.)

Other psychosocial stressors: e.g., natural or manmade disaster, persecution, unwanted pregnancy, out-of-wedlock birth, rape.

Family factors (children and adolescents): In addition to the above, for children and adolescents the following stressors may be considered: cold or distant relationship between parents; overtly hostile relationship between parents; physical or mental disturbance in family members; cold or distant parental behavior toward child; overtly hostile parental behavior toward child; parental intrusiveness; inconsistent parental control; insufficient parental control; insufficient social or cognitive stimulation; anomalous family situation, e.g., single parent, foster family; institutional rearing; loss of nuclear family members.

Axis V. Highest Level of Adaptive Functioning Past Year

Axis V permits the clinician to indicate his or her judgment of an individual's highest level of adaptive functioning (for at least a few months) during the past year. This information frequently has prognostic significance, because usually an individual returns to his or her previous level of adaptive functioning after an episode of illness.

As conceptualized here, adaptive functioning is a composite of three major areas: social relations, occupational functioning, and use of leisure time. These three areas are to be considered together, although there is evidence that social relations should be given greater weight because of their particularly great prognostic significance. An assessment of the use of leisure time will affect the overall judgment only when there is no significant impairment in social relations and occupational functioning or when occupational opportunities are limited or absent (e.g., the individual is retired or handicapped).

Social relations include all relations with people, with particular emphasis on family and friends. The breadth and quality of interpersonal relationships should be considered.

Occupational functioning refers to functioning as a worker, student, or homemaker. The amount, complexity, and quality of the work accomplished should be considered. The highest levels of adaptive functioning should be used only when high occupational productivity is not associated with a high level of subjective discomfort.

Use of leisure time includes recreational activities or hobbies. The range and depth of involvement and the pleasure derived should be considered.

The level noted should be descriptive of the individual's functioning regardless of whether or not special circumstances, such as concurrent treatment, may have been necessary to sustain that level.

Levels	Adult examples	Child or adolescent examples
1 SUPERIOR—Unusually effective functioning in social relations, occupational functioning, and use of leisure time.	Single parent living in deteriorating neighborhood takes excellent care of children and home, has warm relations with friends, and finds time for pursuit of hobby.	A 12-year-old girl gets superior grades in school, is extremely popular among her peers, and excels in many sports. She does all of this with apparent ease and comfort.
2 VERY GOOD—Better than average functioning in social relations, occupational functioning, and use of leisure time.	A 65-year-old retired widower does some volunteer work, often sees old friends, and pursues hobbies.	An adolescent boy gets excellent grades, works part-time, has several close friends, and plays banjo in a jazz band. He admits to some distress in "keeping up with everything."
3 GOOD—No more than slight impairment in either social or occupational functioning.	A woman with many friends functions extremely well at a difficult job, but says "the strain is too much."	An 8-year-old boy does well in school, has several friends, but bullies younger children.
4 FAIR—Moderate impairment in either social relations or occupational functioning, *or* some impairment in both.	A lawyer has trouble carrying through assignments; has several acquaintances, but hardly any close friends.	A 10-year-old girl does poorly in school, but has adequate peer and family relations.
5 POOR—Marked impairment in either social relations or occupational functioning, *or* moderate impairment in both.	A man with one or two friends has trouble keeping a job for more than a few weeks.	A 14-year-old boy almost fails in school and has trouble getting along with his peers.

Levels	Adult examples	Child or adolescent examples
6 VERY POOR—Marked impairment in both social relations and occupational functioning.	A woman is unable to do any of her housework and has violent outbursts toward family and neighbors.	A 6-year-old girls needs special help in all subjects and has virtually no peer relationships.
7 GROSSLY IMPAIRED—Gross impairment in virtually all areas of functioning.	An elderly man needs supervision to maintain minimal personal hygiene and is usually incoherent.	A 4-year-old boy needs constant restraint to avoid hurting himself and is almost totally lacking in skills.
0 UNSPECIFIED	No information.	No information.

Examples of How To Record the Results of a DSM-III Multiaxial Evaluation

EXAMPLE 1

Axis I:	296.23 303.93	Major Depression, Single Episode, with Melancholia Alcohol Dependence, In Remission
Axis II:	301.60	Dependent Personality Disorder (Provisional, rule out Borderline Personality Disorder)
Axis III:		Alcoholic cirrhosis of liver
Axis IV:		Psychosocial stressors: anticipated retirement and change in residence with loss of contact with friends Severity: 4—Moderate
Axis V:		Highest level of adaptive functioning past year: 3—Good

EXAMPLE 2

Axis I:	304.03	Heroin Dependence, In Remission
Axis II:	301.70	Antisocial Personality Disorder (Principal diagnosis); prominent paranoid traits
Axis III:		None
Axis IV:		Psychosocial stressors: No information Severity: 0—Unspecified
Axis V:		Highest level of adaptive functioning past year: 5—Poor

EXAMPLE 3

Axis I:	295.92 V62.89	Schizophrenia, Undifferentiated Type, Chronic Borderline Intellectual Functioning (Provisional)
Axis II:	V71.08	No diagnosis on Axis II

Axis III: Late effects of viral encephalitis

Axis IV: Psychosocial stressors: death of mother
Severity: 6—Extreme

Axis V: Highest level of adaptive functioning past year: 6—Very poor

DIAGNOSTIC CRITERIA

Diagnostic criteria appear at the end of the text describing each specific diagnosis.

These criteria are offered as useful guides for making the diagnosis, since it has been demonstrated that the use of such criteria enhances diagnostic agreement among clinicians. It should be understood, however, that for most of the categories the criteria are based on clinical judgment, and have not yet been fully validated; with further experience and study, the criteria will, in many cases, undoubtedly be revised.

Designation by capital letters indicates multiple criteria the presence of *all* of which constitutes the guide to making the diagnosis.

TYPES OF INFORMATION IN THE TEXT

In order to ensure consistency and comprehensiveness in the descriptions of the disorders, information has been included under each of the following headings. In some instances, when many of the specific disorders, such as Substance Use Disorders, share common features, this information is included in the introduction to the entire section.

The first paragraph states the essential features of the disorder. These are the features that are generally required to make the diagnosis and that are always present.

Associated features. Features that are often, but not invariably, present.

Age at onset. The age when the disorder usually becomes apparent.

Course. The usual course or outcome of the disorder.

Impairment. Conceptualized primarily as impairment in social and occupational functioning.

Complications. Disorders or events (e.g., suicide) that may develop as a result of the disorder. In some cases the distinction among complications, impairment, and associated features is arbitrary.

Predisposing factors. Characteristics of an individual that can be identified before the development of the disorder and that place him or her at higher risk for developing the disorder. Not included in this section are general societal or environmental conditions (such as poverty) that may predispose all individuals exposed to these conditions to develop the disorder.

Prevalence. The prevalence of the disorder is often expressed as the proportion of adults who at some time in their lives met the criteria for the disorder. This method of presentation has the advantage of being readily understandable, but it is highly dependent on the age at onset and the relative proportion of individuals in the population who have reached that age. The data are often presented as a range, based on more than a single study.

When data from epidemiological studies are not available, the prevalence is stated in general terms preceded by the word "apparently" to indicate that the judgment is based on clinical experience. The term "apparently rare" is applied to disorders that may not be seen by a clinician in many years of practice.

Sex ratio. The relative frequency with which the disorder is diagnosed in men and women.

Familial pattern. Indication of whether the disorder is more common among biologically related family members than in the general population. When this is the case, it does not necessarily indicate a genetic mechanism. Unless positive information has been replicated in several studies, "No information" is noted.

Differential diagnosis. Disorders that should be distinguished from the one being presented are discussed, generally in the order in which they appear in the classification.

EXPLANATION OF TERMS AND CONVENTIONS

Atypical. This term is used to indicate a category within a class of disorders that is residual to the specific categories in that class, although it is recognized that in some settings what is regarded as an atypical disorder may actually be more common than any of the specific disorders in that particular class. (In the literature the term "atypical" has sometimes been used in a different sense—to describe a specific diagnostic category that has unusual features.)

Physical disorders. The term "physical disorders" is used to refer to any disorder listed in ICD-9-CM outside the chapter on mental disorders.

Terms in parentheses. In order to facilitate the identification of the categories that in DSM-II were grouped together in the class of Neuroses, the DSM-II terms are included separately in parentheses after the corresponding categories. These DSM-II terms are included in ICD-9-CM and therefore are acceptable as alternatives to the recommended DSM-III terms that precede them.

Not due to another disorder. This phrase is used to indicate that the disorder being described is not diagnosed if the disturbance is apparently symptomatic of another disorder. For example, in the diagnostic criteria for Schizophrenia, there is the phrase, "Not due to any Organic Mental Disorder." This means that the diagnosis of Schizophrenia is not given if the characteristic symptoms, such as delusions or hallucinations, are caused by an Organic Mental Disorder.

DSM-III CLASSIFICATION: AXES I AND II CATEGORIES AND CODES

All official DSM-III codes and terms are included in ICD-9-CM. However, in order to differentiate those DSM-III categories that use the same ICD-9-CM codes, unofficial non-ICD-9-CM codes are provided in parentheses for use when greater specificity is necessary.

The long dashes indicate the need for a fifth-digit subtype or other qualifying term.

DISORDERS USUALLY FIRST EVIDENT IN INFANCY, CHILDHOOD OR ADOLESCENCE

Mental retardation

(Code in fifth digit: 1 = with other behavioral symptoms [requiring attention or treatment and that are not part of another disorder], 0 = without other behavioral symptoms.)

317.0(x)	Mild mental retardation, ———
318.0(x)	Moderate mental retardation, ———
318.1(x)	Severe mental retardation, ———
318.2(x)	Profound mental retardation, ———
319.0(x)	Unspecified mental retardation, ———

Attention deficit disorder

314.01	with hyperactivity
314.00	without hyperactivity
314.80	residual type

Conduct disorder

312.00	undersocialized, aggressive
312.10	undersocialized, nonaggressive
312.23	socialized, aggressive
312.21	socialized, nonaggressive
312.90	atypical

Anxiety disorders of childhood or adolescence

309.21	Separation anxiety disorder
313.21	Avoidant disorder of childhood or adolescence
313.00	Overanxious disorder

Other disorders of infancy, childhood or adolescence

313.89	Reactive attachment disorder of infancy
313.22	Schizoid disorder of childhood or adolescence
313.23	Elective mutism
313.81	Oppositional disorder
313.82	Identity disorder

Eating disorders

307.10	Anorexia nervosa
307.51	Bulimia
307.52	Pica
307.53	Rumination disorder of infancy
307.50	Atypical eating disorder

Stereotyped movement disorders

307.21	Transient tic disorder
307.22	Chronic motor tic disorder
307.23	Tourette's disorder
307.20	Atypical tic disorder
307.30	Atypical stereotyped movement disorder

Other disorders with physical manifestations

307.00	Stuttering
307.60	Functional enuresis
307.70	Functional encopresis
307.46	Sleepwalking disorder
307.46	Sleep terror disorder (307.49)

Pervasive developmental disorders

Code in fifth digit: 0 = full syndrome present, 1 = residual state.

299.0x	Infantile autism, ———
299.9x	Childhood onset pervasive developmental disorder, ———
299.8x	Atypical, ———

Specific developmental disorders
Note: These are coded on Axis II.

315.00	Developmental reading disorder
315.10	Developmental arithmetic disorder
315.31	Developmental language disorder
315.39	Developmental articulation disorder
315.50	Mixed specific developmental disorder
315.90	Atypical specific developmental disorder

ORGANIC MENTAL DISORDERS

Section 1. Organic mental disorders whose etiology or pathophysiological process is listed below (taken from the mental disorders section of ICD-9-CM).

Dementias arising in the senium and presenium

Primary degenerative dementia, senile onset,
290.30 with delirium
290.20 with delusions
290.21 with depression
290.00 uncomplicated

Code in fifth digit:
1 = with delirium, 2 = with delusions, 3 = with depression, 0 = uncomplicated.

290.1x Primary degenerative dementia, presenile onset, ______
290.4x Multi-infarct dementia, ______

Substance-induced

Alcohol
303.00 intoxication
291.40 idiosyncratic intoxication
291.80 withdrawal
291.00 withdrawal delirium
291.30 hallucinosis
291.10 amnestic disorder

Code severity of dementia in fifth digit:
1 = mild, 2 = moderate, 3 = severe, 0 = unspecified.

291.2x Dementia associated with alcoholism, ______

Barbiturate or similarly acting sedative or hypnotic
305.40 intoxication (327.00)
292.00 withdrawal (327.01)
292.00 withdrawal delirium (327.02)
292.83 amnestic disorder (327.04)

Opioid
305.50 intoxication (327.10)
292.00 withdrawal (327.11)

Cocaine
305.60 intoxication (327.20)

Amphetamine or similarly acting sympathomimetic
305.70 intoxication (327.30)
292.81 delirium (327.32)
292.11 delusional disorder (327.35)
292.00 withdrawal (327.31)

Phencyclidine (PCP) or similarly acting arylcyclohexylamine
305.90 intoxication (327.40)
292.81 delirium (327.42)
292.90 mixed organic mental disorder (327.49)

Hallucinogen
305.30 hallucinosis (327.56)
292.11 delusional disorder (327.55)
292.84 affective disorder (327.57)

Cannabis
305.20 intoxication (327.60)
292.11 delusional disorder (327.65)

Tobacco
292.00 withdrawal (327.71)

Caffeine
305.90 intoxication (327.80)

Other or unspecified substance
305.90 intoxication (327.90)
292.00 withdrawal (327.91)
292.81 delirium (327.92)
292.82 dementia (327.93)
292.83 amnestic disorder (327.94)
292.11 delusional disorder (327.95)
292.12 hallucinosis (327.96)
292.84 affective disorder (327.97)
292.89 personality disorder (327.98)
292.90 atypical or mixed organic mental disorder (327.99)

Section 2. Organic brain syndromes whose etiology or pathophysiological process is either noted as an additional diagnosis from outside the mental disorders section of ICD-9-CM or is unknown.

293.00 Delirium
294.10 Dementia
294.00 Amnestic syndrome
293.81 Organic delusional syndrome
293.82 Organic hallucinosis
293.83 Organic affective syndrome
310.10 Organic personality syndrome
294.80 Atypical or mixed organic brain syndrome

SUBSTANCE USE DISORDERS

Code in fifth digit: 1 = continuous, 2 = episodic, 3 = in remission, 0 = unspecified.

305.0x Alcohol abuse, ______
303.9x Alcohol dependence (Alcoholism), ______
305.4x Barbiturate or similarly acting sedative or hypnotic abuse,
304.1x Barbiturate or similarly acting sedative or hypnotic dependence, ______
305.5x Opioid abuse, ______
304.0x Opioid dependence, ______
305.6x Cocaine abuse, ______
305.7x Amphetamine or similarly acting sympathomimetic abuse, ______
304.4x Amphetamine or similarly acting sympathomimetic dependence, ______
305.9x Phencyclidine (PCP) or similarly acting arylcyclohexylamine abuse, ______ (328.4x)
305.3x Hallucinogen abuse, ______
305.2x Cannabis abuse, ______
304.3x Cannabis dependence, ______
305.1x Tobacco dependence, ______
305.9x Other, mixed or unspecified substance abuse, ______
304.6x Other specified substance dependence, ______
304.9x Unspecified substance dependence, ______
304.7x Dependence on combination of opioid and other nonalcoholic substance, ______
304.8x Dependence on combination of substances, excluding opioids and alcohol, ______

SCHIZOPHRENIC DISORDERS

Code in fifth digit: 1 = subchronic, 2 = chronic, 3 = subchronic with acute exacerbation, 4 = chronic with acute exacerbation, 5 = in remission, 0 = unspecified.

Schizophrenia,
295.1x disorganized, ______
295.2x catatonic, ______
295.3x paranoid, ______
295.9x undifferentiated, ______
295.6x residual, ______

PARANOID DISORDERS

297.10 Paranoia
297.30 Shared paranoid disorder
298.30 Acute paranoid disorder
297.90 Atypical paranoid disorder

PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED

295.40 Schizophreniform disorder
298.80 Brief reactive psychosis
295.70 Schizoaffective disorder
298.90 Atypical psychosis

NEUROTIC DISORDERS: These are included in Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders. In order to facilitate the identification of the categories that in DSM-II were grouped together in the class of Neuroses, the DSM-II terms are included separately in parentheses after the corresponding categories. These DSM-II terms are included in ICD-9-CM and therefore are acceptable as alternatives to the recommended DSM-III terms that precede them.

AFFECTIVE DISORDERS

Major affective disorders

Code major depressive episode in fifth digit: 6 = in remission, 4 = with psychotic features (the unofficial non-ICD-9-CM fifth digit 7 may be used instead to indicate that the psychotic features are mood-incongruent), 3 = with melancholia, 2 = without melancholia, 0 = unspecified.

Code manic or mixed episode in fifth digit: 6 = in remission, 4 = with psychotic features (the unofficial non-ICD-9-CM fifth digit 7 may be used instead to indicate that the psychotic features are mood-incongruent), 2 = without psychotic features, 0 = unspecified.

Bipolar disorder,
296.6x mixed, ______
296.4x manic, ______
296.5x depressed, ______

Major depression,
296.2x single episode, ______
296.3x recurrent, ______

Other specific affective disorders

301.13	Cyclothymic disorder
300.40	Dysthymic disorder (or Depressive neurosis)

Atypical affective disorders

296.70	Atypical bipolar disorder
296.82	Atypical depression

ANXIETY DISORDERS

Phobic disorders (or Phobic neuroses)

300.21	Agoraphobia with panic attacks
300.22	Agoraphobia without panic attacks
300.23	Social phobia
300.29	Simple phobia

Anxiety states (or Anxiety neuroses)

300.01	Panic disorder
300.02	Generalized anxiety disorder
300.30	Obsessive compulsive disorder (or Obsessive compulsive neurosis)

Post-traumatic stress disorder

308.30	acute
309.81	chronic or delayed
300.00	Atypical anxiety disorder

SOMATOFORM DISORDERS

300.81	Somatization disorder
300.11	Conversion disorder (or Hysterical neurosis, conversion type)
307.80	Psychogenic pain disorder
300.70	Hypochondriasis (or Hypochondriacal neurosis)
300.70	Atypical somatoform disorder (300.71)

DISSOCIATIVE DISORDERS (OR HYSTERICAL NEUROSES, DISSOCIATIVE TYPE)

300.12	Psychogenic amnesia
300.13	Psychogenic fugue
300.14	Multiple personality
300.60	Depersonalization disorder (or Depersonalization neurosis)
300.15	Atypical dissociative disorder

PSYCHOSEXUAL DISORDERS

Gender identity disorders

Indicate sexual history in the fifth digit of Transsexualism code: 1 = asexual, 2 = homosexual 3 = heterosexual, 0 = unspecified.

302.5x	Transsexualism,
302.60	Gender identity disorder of childhood
302.85	Atypical gender identity disorder

Paraphilias

302.81	Fetishism
302.30	Transvestism
302.10	Zoophilia
302.20	Pedophilia
302.40	Exhibitionism
302.82	Voyeurism
302.83	Sexual masochism
302.84	Sexual sadism
302.90	Atypical paraphilia

Psychosexual dysfunctions

302.71	Inhibited sexual desire
302.72	Inhibited sexual excitement
302.73	Inhibited female orgasm
302.74	Inhibited male orgasm
302.75	Premature ejaculation
302.76	Functional dyspareunia
306.51	Functional vaginismus
302.70	Atypical psychosexual dysfunction

Other psychosexual disorders

302.00	Ego-dystonic homosexuality
302.89	Psychosexual disorder not elsewhere classified

FACTITIOUS DISORDERS

300.16	Factitious disorder with psychological symptoms
301.51	Chronic factitious disorder with physical symptoms
300.19	Atypical factitious disorder with physical symptoms

DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED

312.31	Pathological gambling
312.32	Kleptomania
312.33	Pyromania
312.34	Intermittent explosive disorder
312.35	Isolated explosive disorder
312.39	Atypical impulse control disorder

ADJUSTMENT DISORDER

309.00	with depressed mood
309.24	with anxious mood
309.28	with mixed emotional features
309.30	with disturbance of conduct
309.40	with mixed disturbance of emotions and conduct
309.23	with work (or academic) inhibition
309.83	with withdrawal
309.90	with atypical features

PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION

Specify physical condition on Axis III.

316.00	Psychological factors affecting physical condition

PERSONALITY DISORDERS

Note: These are coded on Axis II.

301.00	Paranoid
301.20	Schizoid
301.22	Schizotypal
301.50	Histrionic
301.81	Narcissistic
301.70	Antisocial
301.83	Borderline
301.82	Avoidant
301.60	Dependent
301.40	Compulsive
301.84	Passive-Aggressive
301.89	Atypical, mixed or other personality disorder

V CODES FOR CONDITIONS NOT ATTRIBUTABLE TO A MENTAL DISORDER THAT ARE A FOCUS OF ATTENTION OR TREATMENT

V65.20	Malingering
V62.89	Borderline intellectual functioning (V62.88)
V71.01	Adult antisocial behavior
V71.02	Childhood or adolescent antisocial behavior
V62.30	Academic problem
V62.20	Occupational problem
V62.82	Uncomplicated bereavement
V15.81	Noncompliance with medical treatment
V62.89	Phase of life problem or other life circumstance problem
V61.10	Marital problem
V61.20	Parent-child problem
V61.80	Other specified family circumstances
V62.81	Other interpersonal problem

ADDITIONAL CODES

300.90	Unspecified mental disorder (nonpsychotic)
V71.09	No diagnosis or condition on Axis I
799.90	Diagnosis or condition deferred on Axis I

V71.09	No diagnosis on Axis II
799.90	Diagnosis deferred on Axis II

ON BEING SANE IN INSANE PLACES

D. L. Rosenhan

If sanity and insanity exist, how shall we know them?

The question is neither capricious nor itself insane. However much we may be personally convinced that we can tell the normal from the abnormal, the evidence is simply not compelling. It is commonplace, for example, to read about murder trials wherein eminent psychiatrists for the defense are contradicted by equally eminent psychiatrists for the prosecution on the matter of the defendant's sanity. More generally, there are a great deal of conflicting data on the reliability, utility, and meaning of such terms as "sanity," "insanity," "mental illness," and "schizophrenia" (*1*). Finally, as early as 1934, Benedict suggested that normality and abnormality are not universal (*2*). What is viewed as normal in one culture may be seen as quite aberrant in another. Thus, notions of normality and abnormality may not be quite as accurate as people believe they are.

To raise questions regarding normality and abnormality is in no way to question the fact that some behaviors are deviant or odd. Murder is deviant. So, too, are hallucinations. Nor does raising such questions deny the existence of the personal anguish that is often associated with "mental illness." Anxiety and depression exist. Psychological suffering exists. But normality and abnormality, sanity and insanity, and the diagnoses that flow from them may be less substantive than many believe them to be.

At its heart, the question of whether the sane can be distinguished from the insane (and whether degrees of insanity can be distinguished from each other) is a simple matter: do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them? From Bleuler, through Kretchmer, through the formulators of the recently revised *Diagnostic and Statistical Manual* of the American Psychiatric Association, the belief has been strong that patients present symptoms, that those symptoms can be categorized, and, implicitly, that the sane are distinguishable from the insane. More recently, however, this belief has been questioned. Based in part on theoretical and anthropological considerations, but also on philosophical, legal, and therapeutic ones, the view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of the observers and are not valid summaries of characteristics displayed by the observed (*3–5*).

Gains can be made in deciding which of these is more nearly accurate by getting normal people (that is, people who do not have, and have never suffered, symptoms of serious psychiatric disorders) admitted to psychiatric hospitals and then determining whether they were discovered to be sane and, if so, how. If the sanity of such pseudopatients were always detected, there would be prima facie evidence that a sane individual can be distinguished from the insane context in which he is found. Normality (and presumably abnormality) is distinct enough that it can be recognized wherever it occurs, for it is carried within the person. If, on the other hand, the sanity of the pseudopatients were never discovered, serious difficulties would arise for those who support traditional modes of psychiatric diagnosis. Given that the hospital staff was not incompetent, that the pseudopatient had been behaving as sanely as he had been outside of the hospital, and that it had never been previously suggested that he belonged in a psychiatric hospital, such an unlikely outcome would support the view that psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him.

This article describes such an experiment. Eight sane people gained secret admission to 12 different hospitals (*6*). Their diagnostic experiences constitute the data of the first part of this article; the remainder is devoted to a description of their experiences in psychiatric institutions. Too few psychiatrists and psychologists, even those who have worked in such hospitals, know what the experience is like. They rarely talk about it with former patients, perhaps because they distrust information coming from the previously insane. Those who have worked in psychiatric hospitals are likely to have adapted so thoroughly to the settings that they are insensitive to the impact of that experience. And while there have been occasional reports of researchers who submitted themselves to psychiatric hospitalization (*7*), these researchers have commonly remained in the hospitals for short periods of time, often with the knowledge of the hospital staff. It is difficult to know the extent to which they were treated like patients or like research colleagues. Nevertheless, their reports about the inside of the psychiatric hospital have been valuable. This article extends those efforts.

Pseudopatients and Their Settings

The eight pseudopatients were a varied group. One was a psychology graduate student in his 20's. The remaining seven were older and "established." Among them were three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife. Three pseudopatients were women, five were men. All of them employed pseudonyms, lest their alleged diagnoses embarrass them later. Those who were in mental health professions alleged another occupation in order to avoid the

Reprinted by permission from SCIENCE, Vol. 179, 1973, pp. 250-258. Copyright © 1973 American Association for the Advancement of Science.

special attentions that might be accorded by staff, as a matter of courtesy or caution, to ailing colleagues (*8*). With the exception of myself (I was the first pseudopatient and my presence was known to the hospital administrator and chief psychologist and, so far as I can tell, to them alone), the presence of pseudopatients and the nature of the research program was not known to the hospital staffs (*9*).

The settings were similarly varied. In order to generalize the findings, admission into a variety of hospitals was sought. The 12 hospitals in the sample were located in five different states on the East and West coasts. Some were old and shabby, some were quite new. Some were research-oriented, others not. Some had good staff-patient ratios, others were quite understaffed. Only one was a strictly private hospital. All of the others were supported by state or federal funds or, in one instance, by university funds.

After calling the hospital for an appointment, the pseudopatient arrived at the admissions office complaining that he had been hearing voices. Asked what the voices said, he replied that they were often unclear, but as far as he could tell they said "empty," "hollow," and "thud." The voices were unfamiliar and were of the same sex as the pseudopatient. The choice of these symptoms was occasioned by their apparent similarity to existential symptoms. Such symptoms are alleged to arise from painful concerns about the perceived meaninglessness of one's life. It is as if the hallucinating person were saying, "My life is empty and hollow." The choice of these symptoms was also determined by the *absence* of a single report of existential psychoses in the literature.

Beyond alleging the symptoms and falsifying name, vocation, and employment, no further alterations of person, history, or circumstances were made. The significant events of the pseudopatient's life history were presented as they had actually occurred. Relationships with parents and siblings, with spouse and children, with people at work and in school, consistent with the aforementioned exceptions, were described as they were or had been. Frustrations and upsets were described along with joys and satisfactions. These facts are important to remember. If anything, they strongly biased the subsequent results in favor of detecting sanity, since none of their histories or current behaviors were seriously pathological in any way.

Immediately upon admission to the psychiatric ward, the pseudopatient ceased simulating *any* symptoms of abnormality. In some cases, there was a brief period of mild nervousness and anxiety, since none of the pseudopatients really believed that they would be admitted so easily. Indeed, their shared fear was that they would be immediately exposed as frauds and greatly embarrassed. Moreover, many of them had never visited a psychiatric ward; even those who had, nevertheless had some genuine fears about what might happen to them. Their nervousness, then, was quite appropriate to the novelty of the hospital setting, and it abated rapidly.

Apart from that short-lived nervousness, the pseudopatient behaved on the ward as he "normally" behaved. The pseudopatient spoke to patients and staff as he might ordinarily. Because there is uncommonly little to do on a psychiatric ward, he attempted to engage others in conversation. When asked by staff how he was feeling, he indicated that he was fine, that he no longer experienced symptoms. He responded to instructions from attendants, to calls for medication (which was not swallowed), and to dining-hall instructions. Beyond such activities as were available to him on the admissions ward, he spent his time writing down his observations about the ward, its patients, and the staff. Initially these notes were written "secretly," but as it soon became clear that no one much cared, they were subsequently written on standard tablets of paper in such public places as the dayroom. No secret was made of these activities.

The pseudopatient, very much as a true psychiatric patient, entered a hospital with no foreknowledge of when he would be discharged. Each was told that he would have to get out by his own devices, essentially by convincing the staff that he was sane. The psychological stresses associated with hospitalization were considerable, and all but one of the pseudopatients desired to be discharged almost immediately after being admitted. They were, therefore, motivated not only to behave sanely, but to be paragons of cooperation. That their behavior was in no way disruptive is confirmed by nursing reports, which have been obtained on most of the patients. These reports uniformly indicate that the patients were "friendly," "cooperative," and "exhibited no abnormal indications."

The Normal Are Not Detectably Sane

Despite their public "show" of sanity, the pseudopatients were never detected. Admitted, except in one case, with a diagnosis of schizophrenia (*10*), each was discharged with a diagnosis of schizophrenia "in remission." The label "in remission" should in no way be dismissed as a formality, for at no time during any hospitalization had any question been raised about any pseudopatient's simulation. Nor are there any indications in the hospital records that the pseudopatient's status was suspect. Rather, the evidence is strong that, once labeled schizophrenic, the pseudopatient was stuck with that label. If the pseudopatient was to be discharged, he must naturally be "in remission"; but he was not sane, nor, in the institution's view, had he ever been sane.

The uniform failure to recognize sanity cannot be attributed to the quality of the hospitals, for, although there were considerable variations among them, several are considered excellent. Nor can it be alleged that there was simply not enough time to observe the pseudopatients. Length of hospitalization ranged from 7 to 52 days, with an average of 19 days. The pseudopatients were not, in fact, carefully observed, but this failure clearly speaks more to traditions within psychiatric hospitals than to lack of opportunity.

Finally, it cannot be said that the failure to recognize the pseudopatients' sanity was due to the fact that they were not behaving sanely. While there was clearly some tension present in all of them, their daily visitors could detect no serious behavioral consequences—nor, indeed, could other patients. It was quite common for the patients to "detect" the pseudopatients' sanity. During the first three hospitalizations, when accurate counts were kept, 35 of a total of 118 patients on the admissions ward voiced their suspicions, some vigorously. "You're not crazy. You're a journalist, or a professor [referring to the continual note-taking]. You're checking up on the hospital." While most of the patients were reassured by the pseudopatient's insistence that he had been sick before he came in but was fine now, some continued to believe that the pseudopatient was sane throughout his hospitalization (*11*). The fact that the patients often recognized normality when staff did not raises important questions.

Failure to detect sanity during the course of hospitalization may be due to the fact that physicians operate with a strong bias toward what statisticians call the type 2 error (*5*). This is to say that physicians are more inclined to call a healthy person sick (a false positive, type 2) than a sick person healthy (a false negative, type 1). The reasons for this are not hard to find: it is clearly more dangerous to misdiagnose illness than health. Better to err on the side of caution, to suspect illness even among the healthy.

But what holds for medicine does not hold equally well for psychiatry. Medical illnesses, while unfortunate, are not commonly pejorative. Psychiatric diagnoses, on the contrary, carry with them personal, legal, and social stigmas (*12*). It was therefore important to see whether the tendency toward diagnosing the sane insane could be reversed. The following experiment was arranged at a research and teaching hospital whose staff had heard these findings but doubted that such an error could occur in their hospital. The staff was informed that at some time during the following 3 months, one or more pseudopatients would attempt to be admitted into the psychiatric hospital. Each staff member was asked to rate each patient who presented himself at admissions or on the ward according to the likelihood that the patient was a pseudopatient. A 10-point scale was used, with a 1 and 2 reflecting high confidence that the patient was a pseudopatient.

Judgments were obtained on 193 patients who were admitted for psychiatric treatment. All staff who had had sustained contact with or primary responsibility for the patient—attendants, nurses, psychiatrists, physicians, and psychologists—were asked to make judgments. Forty-one patients were alleged, with high confidence, to be pseudopatients by at least one member of the staff. Twenty-three were considered suspect by at least one psychiatrist. Nineteen were suspected by one psychiatrist *and* one other staff member. Actually, no genuine pseudopatient (at least from my group) presented himself during this period.

The experiment is instructive. It indicates that the tendency to designate sane people as insane can be reversed when the stakes (in this case, prestige and diagnostic acumen) are high. But what can be said of the 19 people who were suspected of being "sane" by one psychiatrist and another staff member? Were these people truly "sane," or was it rather the case that in the course of avoiding the type 2 error the staff tended to make more errors of the first sort—calling the crazy "sane"? There is no way of knowing. But one thing is certain: any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one.

The Stickiness of Psychodiagnostic Labels

Beyond the tendency to call the healthy sick—a tendency that accounts better for diagnostic behavior on admission than it does for such behavior after a lengthy period of exposure—the data speak to the massive role of labeling in psychiatric assessment. Having once been labeled schizophrenic, there is nothing the pseudopatient can do to overcome the tag. The tag profoundly colors others' perceptions of him and his behavior.

From one viewpoint, these data are hardly surprising, for it has long been known that elements are given meaning by the context in which they occur. Gestalt psychology made this point vigorously, and Asch (*13*) demonstrated that there are "central" personality traits (such as "warm" versus "cold") which are so powerful that they markedly color the meaning of other information in forming an impression of a given personality (*14*). "Insane," "schizophrenic," "manic-depressive," and "crazy" are probably among the most powerful of such central traits. Once a person is designated abnormal, all of his other behaviors and characteristics are colored by that label. Indeed, that label is so powerful that many of the pseudopatients' normal behaviors were overlooked entirely or profoundly misinterpreted. Some examples may clarify this issue.

Earlier I indicated that there were no changes in the pseudopatient's personal history and current status beyond those of name, employment, and, where necessary, vocation. Otherwise, a veridical description of personal history and circumstances was offered. Those circumstances were not psychotic. How were they made consonant with the diagnosis of psychosis? Or were those diagnoses modified in such a way as to bring them into accord with the circumstances of the pseudopatient's life, as described by him?

As far as I can determine, diagnoses were in no way affected by the relative health of the circumstances of a pseudopatient's life. Rather, the reverse occurred: the perception of his circumstances was shaped entirely by the diagnosis. A clear example of such translation is found in the case of a pseudopatient who had had a close relationship with his mother but was rather remote from his father during his early childhool. During adolescence and beyond, however, his father became a close friend, while his relationship with his mother cooled. His present relationship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal. The children had rarely been spanked. Surely there is nothing especially pathological about such a history. Indeed, many readers may see a similar pattern in their own experiences, with no markedly deleterious consequences. Observe, however, how such a history was translated in the psychopathological context, this from the case summary prepared after the patient was discharged.

> This white 39-year-old male . . . manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship to his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of the children, spankings. And while he says that he has several good friends, one senses considerable ambivalence embedded in those relationships also. . . .

The facts of the case were unintentionally distorted by the staff to achieve consistency with a popular theory of the dynamics of a schizophrenic reaction (*15*). Nothing of an ambivalent nature had been described in relations with parents, spouse, or friends. To the extent that ambivalence could be inferred, it was probably not greater than is found in all human relationships. It is true the pseudopatient's relationships with his parents changed over time, but in the ordinary context that would hardly be remarkable—indeed, it might very well be expected. Clearly, the meaning ascribed to his verbalizations (that is, ambivalence, affective instability) was determined by the diagnosis: schizophrenia. An entirely different meaning would have been ascribed if it were known that the man was "normal."

All pseudopatients took extensive notes publicly. Under ordinary circumstances, such behavior would have raised questions in the minds of observers, as, in fact, it did among patients. Indeed, it seemed so certain that the notes would elicit suspicion that elaborate precautions were taken to remove them from the ward each day. But the precautions proved needless. The closest any staff member came to questioning these notes occurred when one pseudopatient asked his physician what kind of medication he was receiving and began to write down the response. "You needn't write it," he was told gently. "If you have trouble remembering, just ask me again."

If no questions were asked of the pseudopatients, how was their writing interpreted? Nursing records for three patients indicate that the writing was seen as an aspect of their pathological behavior. "Patient engages in writing behavior" was the daily nursing comment on one of the pseudopatients who was never questioned about his writing. Given that the patient is in the hospital, he must be psychologically disturbed. And given that he is disturbed, continuous writing must be a behavioral manifestation of that disturbance, perhaps a subset of the compulsive behaviors that are sometimes correlated with schizophrenia.

One tacit characteristic of psychiatric diagnosis is that it locates the sources of aberration within the individual and only rarely within the complex of stimuli that surrounds him. Consequently, behaviors that are stimulated by the environment are commonly misattributed to the patient's disorder. For example, one kindly nurse found a pseudopatient pacing the long hospital corridors. "Nervous, Mr. X?" she asked. "No, bored," he said.

The notes kept by pseudopatients are full of patient behaviors that were misinterpreted by well-intentioned staff. Often enough, a patient would go "berserk" because he had, wittingly or unwittingly, been mistreated by, say, an attendant. A nurse coming upon the scene would rarely inquire even cursorily into the environmental stimuli of the patient's behavior. Rather, she assumed that his upset derived from his pathology, not from his present interactions with other staff members. Occasionally, the staff might assume that the patient's family (especially when they had recently visited) or other patients had stimulated the outburst. But never were the staff found to assume that one of themselves or the structure of the hospital had anything to do with a patient's behavior. One psychiatrist pointed to a group of patients who were sitting outside the cafeteria entrance half an hour before lunchtime. To a group of young residents he indicated that such behavior was characteristic of the oral-acquisitive nature of the syndrome. It seemed not to occur to him that there were very few things to anticipate in a psychiatric hospital besides eating.

A psychiatric label has a life and an influence of its own. Once the impression has been formed that the patient is schizophrenic, the expectation is that he will continue to be schizophrenic. When a sufficient amount of time has passed, during which the patient has done nothing bizarre, he is considered to be in remission and available for discharge. But the label endures beyond discharge, with the unconfirmed expectation that he will behave as a schizophrenic again. Such labels, conferred by mental health professionals, are as influential on the patient as they are on his relatives and friends, and it should not surprise anyone that the diagnosis acts on all of them as a self-fulfilling prophecy. Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly (*5*).

The inferences to be made from these matters are quite simple. Much as Zigler and Phillips have demonstrated that there is enormous overlap in the symptoms presented by patients who have been variously diagnosed (*16*), so there is enormous overlap in the behaviors of the sane and the insane. The sane are not "sane" all of the time. We lose our tempers "for no good reason." We are occasionally depressed or anxious, again for no good reason. And we may find it difficult to get along with one or another person—again for no reason that we can specify. Similarly, the insane are not always insane. Indeed, it was the impression of the pseudopatients while living with them that they were sane for long periods of time—that the bizarre behaviors upon which their diagnoses were allegedly predicated constituted only a small fraction of their total behavior. If it makes no sense to label ourselves permanently depressed on the basis of an occasional depression, then it takes better evidence than is presently available to label all patients insane or schizophrenic on the basis of bizarre behaviors or cognitions. It seems more useful, as Mischel (*17*) has pointed out, to limit our discussions to *behaviors*, the stimuli that provoke them, and their correlates.

It is not known why powerful impressions of personality traits, such as "crazy" or "insane," arise. Conceivably, when the origins of and stimuli that give rise to a behavior are remote or unknown, or when the behavior strikes us as immutable, trait labels regarding the *behaver* arise. When, on the other hand, the origins and stimuli are known and available, discourse is limited to the behavior itself. Thus, I may hallucinate because I am sleeping, or I may hallucinate because I have ingested a peculiar drug. These are termed sleep-induced hallucinations, or dreams, and drug-induced hallucinations, respectively. But when the stimuli to my hallucinations are unknown, that is called craziness, or schizophrenia—as if that inference were somehow as illuminating as the others.

The Experience of Psychiatric Hospitalization

The term "mental illness" is of recent origin. It was coined by people who were humane in their inclinations and who wanted very much to raise the station of (and the public's sympathies toward) the psychologically disturbed from that of witches and "crazies" to one that was akin to the physically ill. And they were at least partially successful, for the treatment of the mentally ill *has* improved considerably over the years. But while treatment has improved, it is doubtful that people really regard the mentally ill in the same way that they view the physically ill. A broken leg is something one recovers from, but mental illness allegedly endures forever (*18*). A broken leg does not threaten the observer, but a crazy schizophrenic? There is by now a host of evidence that attitudes toward the mentally ill are characterized by fear, hostility, aloofness, suspicion, and dread (*19*). The mentally ill are society's lepers.

That such attitudes infect the general population is perhaps not surprising, only upsetting. But that they affect the professionals—attendants, nurses, physicians, psychologists, and social workers—who treat and deal with the mentally ill is more disconcerting, both because such attitudes are self-evidently pernicious and because they are unwitting. Most mental health professionals would insist that they are sympathetic toward the mentally ill, that they are neither avoidant nor hostile. But it is more likely that an exquisite ambivalence characterizes their relations with psychiatric patients, such that their avowed impulses are only part of their entire attitude. Negative attitudes are there too and can easily be detected. Such attitudes should not surprise us. They are the natural offspring of the labels patients wear and the places in which they are found.

Consider the structure of the typical psychiatric hospital. Staff and patients are strictly segregated. Staff have their own living space, including their dining facilities, bathrooms, and assembly places. The glassed quarters that contain the professional staff, which the pseudopatients came to call "the cage," sit out on every dayroom. The staff emerge primarily for caretaking purposes—to give medication, to conduct a therapy or group meeting, to instruct or reprimand a patient. Otherwise, staff keep to themselves, almost as if the disorder that afflicts their charges is somehow catching.

So much is patient-staff segregation the rule that, for four public hospitals in which an attempt was made to measure the degree to which staff and patients mingle, it was necessary to use "time out of the staff cage" as the operational measure. While it was not the case that all time spent out of the cage was spent mingling with patients (attendants, for example, would occasionally emerge to watch television in the dayroom), it was the only way in which one could gather reliable data on time for measuring.

The average amount of time spent by attendants outside of the cage was 11.3 percent (range, 3 to 52 percent). This figure does not represent only time spent mingling with patients, but also includes time spent on such chores as folding laundry, supervising patients while they shave, directing ward clean-up, and sending patients to off-ward activities. It was the relatively rare attendant who spent time talking with patients or playing games with them. It proved impossible to obtain a "percent mingling time" for nurses, since the amount of time they spent out of the cage was too brief. Rather, we counted instances of emergence from the cage. On the average, daytime nurses emerged from the cage 11.5 times per shift, including instances when they left the ward entirely (range, 4 to 39 times). Late afternoon and night nurses were even less available, emerging on the average 9.4 times per shift (range, 4 to 41 times). Data on early morning nurses, who arrived usually after midnight and departed at 8 a.m., are not available because patients were asleep during most of this period.

Physicians, especially psychiatrists, were even less available. They were rarely seen on the wards. Quite commonly, they would be seen only when they arrived and departed, with the remaining time being spent in their offices or in the cage. On the average, physicians emerged on the ward 6.7 times per day (range, 1 to 17 times). It proved difficult to make an accurate estimate in this regard, since physicians often maintained hours that allowed them to come and go at different times.

The hierarchical organization of the psychiatric hospital has been commented on before (*20*), but the latent meaning of that kind of organization is worth noting again. Those with the most power have least to do with patients, and those with the least power are most involved with them. Recall, however, that the acquisition of role-appropriate behaviors occurs main through the observation of others, wi the most powerful having the most i fluence. Consequently, it is understan able that attendants not only spe more time with patients than do a other members of the staff—that is r quired by their station in the hierarch —but also, insofar as they learn fro their superiors' behavior, spend as litt time with patients as they can. Atten ants are seen mainly in the cage, whic is where the models, the action, a the power are.

I turn now to a different set studies, these dealing with staff r sponse to patient-initiated contact. has long been known that the amou of time a person spends with you c be an index of your significance to hi If he initiates and maintains eye co tact, there is reason to believe that is considering your requests and nee If he pauses to chat or actually sto and talks, there is added reason to inf that he is individuating you. In fo hospitals, the pseudopatient approach the staff member with a request whi took the following form: "Pardon m Mr. [or Dr. or Mrs.] X, could you t me when I will be eligible for groun privileges?" (or " . . . when I will presented at the staff meeting?" or ". when I am likely to be discharged?" While the content of the question vari according to the appropriateness of t target and the pseudopatient's (appa ent) current needs the form was a ways a courteous and relevant reque for information. Care was taken nev to approach a particular member of t staff more than once a day, lest t staff member become suspicious or ritated. In examining these data, r member that the behavior of t pseudopatients was neither bizarre n disruptive. One could indeed engage good conversation with them.

The data for these experiments a shown in Table 1, separately for phy cians (column 1) and for nurses a attendants (column 2). Minor diff ences between these four institutio were overwhelmed by the degree which staff avoided continuing conta that patients had initiated. By far, th most common response consisted either a brief response to the questio offered while they were "on the mov and with head averted, or no respon at all.

Table 1. Self-initiated contact by pseudopatients with psychiatrists and nurses and attendants, compared to contact with other groups.

Contact	Psychiatric hospitals		University campus (nonmedical)	University medical center		
				Physicians		
	(1) Psychiatrists	(2) Nurses and attendants	(3) Faculty	(4) "Looking for a psychiatrist"	(5) "Looking for an internist"	(6) No additional comment
Responses						
Moves on, head averted (%)	71	88	0	0	0	0
Makes eye contact (%)	23	10	0	11	0	0
Pauses and chats (%)	2	2	0	11	0	10
Stops and talks (%)	4	0.5	100	78	100	90
Mean number of questions answered (out of 6)	*	*	6	3.8	4.8	4.5
Respondents (No.)	13	47	14	18	15	10
Attempts (No.)	185	1283	14	18	15	10

* Not applicable.

The encounter frequently took the following bizarre form: (pseudopatient) "Pardon me, Dr. X. Could you tell me when I am eligible for grounds privileges?" (physician) "Good morning, Dave. How are you today?" (Moves off without waiting for a response.)

It is instructive to compare these data with data recently obtained at Stanford University. It has been alleged that large and eminent universities are characterized by faculty who are so busy that they have no time for students. For this comparison, a young lady approached individual faculty members who seemed to be walking purposefully to some meeting or teaching engagement and asked them the following six questions.

1) "Pardon me, could you direct me to Encina Hall?" (at the medical school: ". . . to the Clinical Research Center?").

2) "Do you know where Fish Annex is?" (there is no Fish Annex at Stanford).

3) "Do you teach here?"

4) "How does one apply for admission to the college?" (at the medical school: ". . . to the medical school?").

5) "Is it difficult to get in?"

6) "Is there financial aid?"

Without exception, as can be seen in Table 1 (column 3), all of the questions were answered. No matter how rushed they were, all respondents not only maintained eye contact, but stopped to talk. Indeed, many of the respondents went out of their way to direct or take the questioner to the office she was seeking, to try to locate "Fish Annex," or to discuss with her the possibilities of being admitted to the university.

Similar data, also shown in Table 1 (columns 4, 5, and 6), were obtained in the hospital. Here too, the young lady came prepared with six questions. After the first question, however, she remarked to 18 of her respondents (column 4), "I'm looking for a psychiatrist," and to 15 others (column 5), "I'm looking for an internist." Ten other respondents received no inserted comment (column 6). The general degree of cooperative responses is considerably higher for these university groups than it was for pseudopatients in psychiatric hospitals. Even so, differences are apparent within the medical school setting. Once having indicated that she was looking for a psychiatrist, the degree of cooperation elicited was less than when she sought an internist.

Powerlessness and Depersonalization

Eye contact and verbal contact reflect concern and individuation; their absence, avoidance and depersonalization. The data I have presented do not do justice to the rich daily encounters that grew up around matters of depersonalization and avoidance. I have records of patients who were beaten by staff for the sin of having initiated verbal contact. During my own experience, for example, one patient was beaten in the presence of other patients for having approached an attendant and told him, "I like you." Occasionally, punishment meted out to patients for misdemeanors seemed so excessive that it could not be justified by the most radical interpretations of psychiatric canon. Nevertheless, they appeared to go unquestioned. Tempers were often short. A patient who had not heard a call for medication would be roundly excoriated, and the morning attendants would often wake patients with, "Come on, you m——f——s, out of bed!"

Neither anecdotal nor "hard" data can convey the overwhelming sense of powerlessness which invades the individual as he is continually exposed to the depersonalization of the psychiatric hospital. It hardly matters *which* psychiatric hospital—the excellent public ones and the very plush private hospital were better than the rural and shabby ones in this regard, but, again, the features that psychiatric hospitals had in common overwhelmed by far their apparent differences.

Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment (*21*). He is shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but may only respond to such overtures as they make. Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. His personal history and anguish is available to any staff member (often including the "grey lady" and "candy striper" volunteer) who chooses to read his folder, regardless of their therapeutic relationship to him. His personal hygiene and waste evacuation are often monitored. The water closets may have no doors.

At times, depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account. Upon being admitted, I and other pseudopatients took the initial physical examinations in a semipublic room, where staff members went about their own business as if we were not there.

On the ward, attendants delivered verbal and occasionally serious physical abuse to patients in the presence of other observing patients, some of whom (the pseudopatients) were writing it all down. Abusive behavior, on the other hand, terminated quite abruptly when other staff members were known to be coming. Staff are credible witnesses. Patients are not.

A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn't notice us. A group of staff persons might point to a patient in the dayroom and discuss him animatedly, as if he were not there.

One illuminating instance of depersonalization and invisibility occurred with regard to medications. All told, the pseudopatients were administered nearly 2100 pills, including Elavil, Stelazine, Compazine, and Thorazine, to name but a few. (That such a variety of medications should have been administered to patients presenting identical symptoms is itself worthy of note.) Only two were swallowed. The rest were either pocketed or deposited in the toilet. The pseudopatients were not alone in this. Although I have no precise records on how many patients rejected their medications, the pseudopatients frequently found the medications of other patients in the toilet before they deposited their own. As long as they were cooperative, their behavior and the pseudopatients' own in this matter, as in other important matters, went unnoticed throughout.

Reactions to such depersonalization among pseudopatients were intense. Although they had come to the hospital as participant observers and were fully aware that they did not "belong," they nevertheless found themselves caught up in and fighting the process of depersonalization. Some examples: a graduate student in psychology asked his wife to bring his textbooks to the hospital so he could "catch up on his homework"—this despite the elaborate precautions taken to conceal his professional association. The same student, who had trained for quite some time to get into the hospital, and who had looked forward to the experience, "remembered" some drag races that he had wanted to see on the weekend and insisted that he be discharged by that time. Another pseudopatient attempted a romance with a nurse. Subsequently, he informed the staff that he was applying for admission to graduate school in psychology and was very likely to be admitted, since a graduate professor was one of his regular hospital visitors. The same person began to engage in psychotherapy with other patients—all of this as a way of becoming a person in an impersonal environment.

The Sources of Depersonalization

What are the origins of depersonalization? I have already mentioned two. First are attitudes held by all of us toward the mentally ill—including those who treat them—attitudes characterized by fear, distrust, and horrible expectations on the one hand, and benevolent intentions on the other. Our ambivalence leads, in this instance as in others, to avoidance.

Second, and not entirely separate, the hierarchical structure of the psychiatric hospital facilitates depersonalization. Those who are at the top have least to do with patients, and their behavior inspires the rest of the staff. Average daily contact with psychiatrists, psychologists, residents, and physicians combined ranged from 3.9 to 25.1 minutes, with an overall mean of 6.8 (six pseudopatients over a total of 129 days of hospitalization). Included in this average are time spent in the admissions interview, ward meetings in the presence of a senior staff member, group and individual psychotherapy contacts, case presentation conferences, and discharge meetings. Clearly, patients do not spend much time in interpersonal contact with doctoral staff. And doctoral staff serve as models for nurses and attendants.

There are probably other sources. Psychiatric installations are presently in serious financial straits. Staff shortages are pervasive, staff time at a premium. Something has to give, and that something is patient contact. Yet, while financial stresses are realities, too much can be made of them. I have the impression that the psychological forces that result in depersonalization are much stronger than the fiscal ones and that the addition of more staff would not correspondingly improve patient care in this regard. The incidence of staff meetings and the enormous amount of record-keeping on patients, for example, have not been as su stantially reduced as has patient co tact. Priorities exist, even during ha times. Patient contact is not a signi cant priority in the traditional psychi tric hospital, and fiscal pressures do n account for this. Avoidance and d personalization may.

Heavy reliance upon psychotrop medication tacitly contributes to depe sonalization by convincing staff th treatment is indeed being conduct and that further patient contact m not be necessary. Even here, howeve caution needs to be exercised in unde standing the role of psychotropic drug If patients were powerful rather tha powerless, if they were viewed as inte esting individuals rather than diagnost entities, if they were socially significa rather than social lepers, if their a guish truly and wholly compelled o sympathies and concerns, would v not *seek* contact with them, despite t availability of medications? Perhaps f the pleasure of it all?

The Consequences of Labeling and Depersonalization

Whenever the ratio of what is kno to what needs to be known approach zero, we tend to invent "knowledg and assume that we understand mo than we actually do. We seem unab to acknowledge that we simply do know. The needs for diagnosis a remediation of behavioral and em tional problems are enormous. B rather than acknowledge that we a just embarking on understanding, continue to label patients "schiz phrenic," "manic-depressive," and " sane," as if in those words we h captured the essence of understandi The facts of the matter are that have known for a long time that di noses are often not useful or reliab but we have nevertheless continued use them. We now know that we ca not distinguish insanity from sanity. is depressing to consider how that formation will be used.

Not merely depressing, but fright ing. How many people, one wond are sane but not recognized as such our psychiatric institutions? How ma have been needlessly stripped of th privileges of citizenship, from the ri to vote and drive to that of handl their own accounts? How many have feigned insanity in order to avoid the criminal consequences of their behavior, and, conversely, how many would rather stand trial than live interminably in a psychiatric hospital—but are wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned, but nevertheless erroneous, diagnoses? On the last point, recall again that a "type 2 error" in psychiatric diagnosis does not have the same consequences it does in medical diagnosis. A diagnosis of cancer that has been found to be in error is cause for celebration. But psychiatric diagnoses are rarely found to be in error. The label sticks, a mark of inadequacy forever.

Finally, how many patients might be "sane" outside the psychiatric hospital but seem insane in it—not because craziness resides in them, as it were, but because they are responding to a bizarre setting, one that may be unique to institutions which harbor nether people? Goffman (*4*) calls the process of socialization to such institutions "mortification"—an apt metaphor that includes the processes of depersonalization that have been described here. And while it is impossible to know whether the pseudopatients' responses to these processes are characteristic of all inmates—they were, after all, not real patients—it is difficult to believe that these processes of socialization to a psychiatric hospital provide useful attitudes or habits of response for living in the "real world."

Summary and Conclusions

It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals. The hospital itself imposes a special environment in which the meanings of behavior can easily be misunderstood. The consequences to patients hospitalized in such an environment—the powerlessness, depersonalization, segregation, mortification, and self-labeling—seem undoubtedly countertherapeutic.

I do not, even now, understand this problem well enough to perceive solutions. But two matters seem to have some promise. The first concerns the proliferation of community mental health facilities, of crisis intervention centers, of the human potential movement, and of behavior therapies that, for all of their own problems, tend to avoid psychiatric labels, to focus on specific problems and behaviors, and to retain the individual in a relatively nonpejorative environment. Clearly, to the extent that we refrain from sending the distressed to insane places, our impressions of them are less likely to be distorted. (The risk of distorted perceptions, it seems to me, is always present, since we are much more sensitive to an individual's behaviors and verbalizations than we are to the subtle contextual stimuli that often promote them. At issue here is a matter of magnitude. And, as I have shown, the magnitude of distortion is exceedingly high in the extreme context that is a psychiatric hospital.)

The second matter that might prove promising speaks to the need to increase the sensitivity of mental health workers and researchers to the *Catch 22* position of psychiatric patients. Simply reading materials in this area will be of help to some such workers and researchers. For others, directly experiencing the impact of psychiatric hospitalization will be of enormous use. Clearly, further research into the social psychology of such total institutions will both facilitate treatment and deepen understanding.

I and the other pseudopatients in the psychiatric setting had distinctly negative reactions. We do not pretend to describe the subjective experiences of true patients. Theirs may be different from ours, particularly with the passage of time and the necessary process of adaptation to one's environment. But we can and do speak to the relatively more objective indices of treatment within the hospital. It could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behavior were controlled by the situation, rather than being motivated by a malicious disposition. In a more benign environment, one that was less attached to global diagnosis, their behaviors and judgments might have been more benign and effective.

References and Notes

1. P. Ash, *J. Abnorm. Soc. Psychol.* 44, 272 (1949); A. T. Beck, *Amer. J. Psychiat.* 119, 210 (1962); A. T. Boisen, *Psychiatry* 2, 233 (1938); N. Kreitman, *J. Ment. Sci.* 107, 876 (1961); N. Kreitman, P. Sainsbury, J. Morrisey, J. Towers, J. Scrivener, *ibid.*, p. 887; H. O. Schmitt and C. P. Fonda, *J. Abnorm. Soc. Psychol.* 52, 262 (1956); W. Seeman, *J. Nerv. Ment. Dis.* 118, 541 (1953). For an analysis of these artifacts and summaries of the disputes, see J. Zubin, *Annu. Rev. Psychol.* 18, 373 (1967); L. Phillips and J. G. Draguns, *ibid.* 22, 447 (1971).
2. R. Benedict, *J. Gen. Psychol.* 10, 59 (1934).
3. See in this regard H. Becker, *Outsiders: Studies in the Sociology of Deviance* (Free Press, New York, 1963); B. M. Braginsky, D. D. Braginsky, K. Ring, *Methods of Madness: The Mental Hospital as a Last Resort* (Holt, Rinehart & Winston, New York, 1969); G. M. Crocetti and P. V. Lemkau, *Amer. Sociol. Rev.* 30, 577 (1965); E. Goffman, *Behavior in Public Places* (Free Press, New York, 1964); R. D. Laing, *The Divided Self: A Study of Sanity and Madness* (Quadrangle, Chicago, 1960); D. L. Phillips, *Amer. Sociol. Rev.* 28, 963 (1963); T. R. Sarbin, *Psychol. Today* 6, 18 (1972); E. Schur, *Amer. J. Sociol.* 75, 309 (1969); T. Szasz, *Law, Liberty and Psychiatry* (Macmillan, New York, 1963); *The Myth of Mental Illness: Foundations of a Theory of Mental Illness* (Hoeber-Harper, New York, 1963). For a critique of some of these views, see W. R. Gove, *Amer. Sociol. Rev.* 35, 873 (1970).
4. E. Goffman, *Asylums* (Doubleday, Garden City, N.Y., 1961).
5. T. J. Scheff, *Being Mentally Ill: A Sociological Theory* (Aldine, Chicago, 1966).
6. Data from a ninth pseudopatient are not incorporated in this report because, although his sanity went undetected, he falsified aspects of his personal history, including his marital status and parental relationships. His experimental behaviors therefore were not identical to those of the other pseudopatients.
7. A. Barry, *Bellevue Is a State of Mind* (Harcourt Brace Jovanovich, New York, 1971); I. Belknap, *Human Problems of a State Mental Hospital* (McGraw-Hill, New York, 1956); W. Caudill, F. C. Redlich, H. R. Gilmore, E. B. Brody, *Amer. J. Orthopsychiat.* 22, 314 (1952); A. R. Goldman, R. H. Bohr, T. A. Steinberg, *Prof. Psychol.* 1, 427 (1970); unauthored, *Roche Report* 1 (No. 13), 8 (1971).
8. Beyond the personal difficulties that the pseudopatient is likely to experience in the hospital, there are legal and social ones that, combined, require considerable attention before entry. For example, once admitted to a psychiatric institution, it is difficult, if not impossible, to be discharged on short notice, state law to the contrary notwithstanding. I was not sensitive to these difficulties at the outset of the project, nor to the personal and situational emergencies that can arise, but later a writ of habeas corpus was prepared for each of the entering pseudopatients and an attorney was kept "on call" during every hospitalization. I am grateful to John Kaplan and Robert Bartels for legal advice and assistance in these matters.
9. However distasteful such concealment is, it was a necessary first step to examining these questions. Without concealment, there would have been no way to know how valid these experiences were; nor was there any way of knowing whether whatever detections occurred were a tribute to the diagnostic acumen of the staff or to the hospital's rumor network. Obviously, since my concerns are general ones that cut across indi-

vidual hospitals and staffs, I have respected their anonymity and have eliminated clues that might lead to their identification.

10. Interestingly, of the 12 admissions, 11 were diagnosed as schizophrenic and one, with the identical symptomatology, as manic-depressive psychosis. This diagnosis has a more favorable prognosis, and it was given by the only private hospital in our sample. On the relations between social class and psychiatric diagnosis, see A. deB. Hollingshead and F. C. Redlich, *Social Class and Mental Illness: A Community Study* (Wiley, New York, 1958).

11. It is possible, of course, that patients have quite broad latitudes in diagnosis and therefore are inclined to call many people sane, even those whose behavior is patently aberrant. However, although we have no hard data on this matter, it was our distinct impression that this was not the case. In many instances, patients not only singled us out for attention, but came to imitate our behaviors and styles.

12. J. Cumming and E. Cumming, *Community Ment. Health* 1, 135 (1965); A. Farina and K. Ring, *J. Abnorm. Psychol.* 70, 47 (1965); H. E. Freeman and O. G. Simmons, *The Mental Patient Comes Home* (Wiley, New York, 1963); W. J. Johannsen, *Ment. Hygiene* 53, 218 (1969); A. S. Linsky, *Soc. Psychiat.* 5, 166 (1970).

13. S. E. Asch, *J. Abnorm. Soc. Psychol.* 41, 258 (1946); *Social Psychology* (Prentice-Hall, New York, 1952).

14. See also I. N. Mensh and J. Wishner, *J. Personality* 16, 188 (1947); J. Wishner, *Psychol. Rev.* 67, 96 (1960); J. S. Bruner and R. Tagiuri, in *Handbook of Social Psychology*, G. Lindzey, Ed. (Addison-Wesley, Cambridge, Mass., 1954), vol. 2, pp. 634–654; J. S. Bruner, D. Shapiro, R. Tagiuri, in *Person Perception and Interpersonal Behavior*, R. Tagiuri and L. Petrullo, Eds. (Stanford Univ. Press, Stanford, Calif., 1958), pp. 277–288.

15. For an example of a similar self-fulfilling prophecy, in this instance dealing with the "central" trait of intelligence, see R. Rosenthal and L. Jacobson, *Pygmalion in the Classroom* (Holt, Rinehart & Winston, New York, 1968).

16. E. Zigler and L. Phillips, *J. Abnorm. Soc. Psychol.* 63, 69 (1961). See also R. K. Freudenberg and J. P. Robertson, *A.M.A. Arch. Neurol. Psychiatr.* 76, 14 (1956).

17. W. Mischel, *Personality and Assessment* (Wiley, New York, 1968).

18. The most recent and unfortunate instance of this tenet is that of Senator Thomas Eagleton.

19. T. R. Sarbin and J. C. Mancuso, *J. Clin. Consult. Psychol.* 35, 159 (1970); T. R. Sarbin, *ibid.* 31, 447 (1967); J. C. Nunnally, Jr., *Popular Conceptions of Mental Health* (Holt, Rinehart & Winston, New York, 1961).

20. A. H. Stanton and M. S. Schwartz, *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment* (Basic, New York, 1954).

21. D. B. Wexler and S. E. Scoville, *Ariz. Law Rev.* 13, 1 (1971).

22. I thank W. Mischel, E. Orne, and M. S. Rosenhan for comments on an earlier draft of this manuscript.

Notes for:

On Being Sane in Insane Places

The eight pseudopatients were a psychology graduate student, three psychologists, a pediatrician, a psychiatrist, a painter and a housewife. They called the hospital for an appointment and upon arrival, complained of hearing voices ("hollow", "empty", and "thud") and nervousness. Some started off writing notes "secretly" then became "more open" about note-taking. "Patients" palmed or "cheeked" their medications...could this have prolonged their hospitalization?

Rosenhan asserts that the physicians made Type II errors...a false positive. If these events had "actually" occurred would it have been a Type II error.

Rosenhan asserts that staff rated a significant proportion of the real patients as pseudopatients. Does this mean that we are poor in our judgments, or that treatment was working?

It is important to recognize that there are *central personality traits* i.e. traits that are so powerful that they markedly color the meaning of other information in forming an impression of a given personality. **Thus elements of personality are given in the context in which they occur**. Yet, Rosenhan apparently fails to recognize this when it comes to analysis of his own experiment. However, in the field of aging, "**elderly**" may be one of these central personality traits.

There is a good point about how staff perceive client behavior and how clients or other "insiders" might perceive client behavior.

One point made is that psychiatric diagnoses tend to locate the source of the problem within the patient and not within the complex of stimuli in the surrounding environment. One must also be wary of the tautology which sometimes surrounds psychiatric problems and psychiatric diagnoses.

232

Where does one draw the lines between "depersonalization and segregation" and confidentiality of patient's treatment? Or between the person's right to privacy and the staff's right to prevent suicides and aggressive behavior?

What would have happened if Rosenhan's students had entered a medical hospital and complained of non-specific G.I. troubles? Would he have complained about the "nurses' cage" or the fact that hospital staff have complete power over the medical patients? Would he have made a point that some of the medical patients appeared to be in good health? Is a medical hospital any more or less "insane" than a psychiatric hospital?

Are there real dangers though in making "too much" of a psychiatric problem? How does the fact that we live in a very litigious world affect our practice of mental health? Are we *expected* and *encouraged* to make Type II errors in our judgments?

A major feature of the Rosenhan article is that is was one of the first articles which got people to thinking about the phenomenon of psychiatric hospitalization. However, a major criticism of the article is that, just as shoemakers expect to see people with shoes that need fixing, mental health professionals expect to see people with mental health problems. When would a person reasonably go to a tailor to get his or her shoes repaired? Similarly, when would a person go to a mental health professional when something else was the problem or there were no problems whatsoever? Generally, only when a physical problem was manifesting itself psychologically would this occur, and most mental health professionals are well-trained to actively refer clients to medical personnel when a physical exam has not recently been conducted

The chapter in the text that is called Psychopathology II is sub-titled "A review of selected disorders". This is exactly what we are presenting. We are not attempting to turn everyone who takes this course into diagnosticians. All we want to do is make the people who come into the most frequent contact with the elderly familiar with some of the mental disorders that are found within the older segment of our population. By becoming acquainted with the usual symptoms and with the medications that might be being used you can better serve your clients. You will also have a better understanding of why they may exhibit sometimes bizzare behavior.

Organic Brain Dysfunction

Organic Brain Dysfunction (OBD) in the text and Organic Mental Disorder (OMD) in the DSM III are different terms for the same thing. They both encompass abnormal psychological or behavioral signs and symptoms whose origins lie in an identified cerebral disease. The key to the diagnosis of these conditions lies in tangible proof from a clinical history, laboratory findings, or physical examination. As mentioned in the text, this is the psychiatric disorder that is most feared by the elderly. Any of your students, who are in direct service, should be able to confirm this from conversations with their clients. "I just don't want to live to be so old that I get senile."

It is extremely important that the clinician be able to differentiate between delerium, dementia, and pseudodementia. The presenting symptoms may be very vague in elderly patients or they may be opposite of what is expected. Delerium and pseudodementia can often be reversed; but, only if diagnosed correctly in the first place. It is very easy to "write off" the confused elderly person as being demented, because that is what the examiner expects them to be. Clients with pseudodementia may appear unconcerned or apathetic about cognitive losses that they demonstrate. The patient who suffers from true dementia knows that they are not functioning well and will be upset and frustrated. He or she may attempt to disguise their lost skills. They may pretend not to have heard the question or they may claim to have said the correct word, placing the blame on the listener.

It might be helpful for your students to have listed on a flip chart or blackboard the symptoms of delerium, dementia, and pseudodementia. Stress the contrasts, such as the relatively rapid onset of delerium as opposed to the insidious progression of dementia. Rarely will the family of a demented patient be able to pinpoint a specific point when their relative became demented. This is especially true of people who have Alzheimer's Disease. This is the most characteristic disease of the senile dementias. It is seen twice as often in women as in men and the cause is not yet known. 96% of those diagnosed with Alzheimer's Disease are over 40 years of age and 10% of Americans over age 65 are afflicted with the disease to some degree. Alzheimer's accounts for 80% of the dementing diseases of the elderly.

Another dementia seen among elderly clients is multi-infarct dementia. This dementia is caused by multiple infarcts in the brain. To a lay person, this is best explained as comperable to suffering many small strokes that destroy portions of the brain. The deterioration in these cases will be step-wise. An infarct will result in a certain level of deficit and the patient will remain at that level, or plateau, until another infarct strikes. At that time they will appear even more demented. Individuals with multi-infarct dementia often have a history of either hypertension or diabetes.

There are other dementias listed in the DSM-III. You might wish to review these with the students. Using the DSM-III, you and the students can list the criteria for each diagnosis.

Schizophrenia

In this session you will be discussing a disorder that is probably a group of disorders. Schizophrenia is the name that we have given to a disorder that leaves its victim with disturbences in reality orientation, thought processes, and social involvement. Schizophrenia means "split mind". The mind of the victim splits or breaks amid associations. Schizophrenia is a common and unsolved mental problem in the world today. Studies indicate that 1% of the U.S. population is or has been afflicted by this disorder. The person who has schizophrenia may live in his or her own world. This is usually an extremely hostile world. This world is often populated by "voices" and "visions". The voices are accusatory and condemning and the visions frightening and punishing. A schizophrenic may be off in their own world; it is not a pleasant world, though.

Review the theories on the etiology of schizophrenia that are presented in the text. As stated in the text, there does seem to be a genetic factor involved in the development of schizophrenia. A higher incidence of schizophrenia occurs in the relatives of a schizophrenic than you would expect to find in ther general population. Twin studies show that if one of monozygotic (identical) twins becomes schizophrenic, the probability that the other will become schizophrenic is greater than between dyzygotic (fraternal) twins. Even children of schizophrenic mothers, who have been adopted away shortly after birth, have a higher incidence of schizophrenia than do adopted children born to non-schizophrenic mothers.

236

In addition to the biochemical influences mentioned in the text, there is also some evidence to support the psychosocial theories. One theorist says that a person becomes schizophrenic, not because of what other people do to them; but, rather "because of what he does with what was done to him." This statement is based on the belief that there is a predisposition of the personality to crack, or break, under certain levels of stress. A characteristic such as hypersensitivity, might escalate into suspician or paranoia, under times of extreme stress. Another model proposes schizophrenia as an episodic disorder. Major life events, especially those that are stressful, may trigger a person who is predisposed to schizophrenia. The relationships within the family of a schizophrenic appear very strange to someone on the outside. The family rules appear rigid and the family is often referred to as odd or isolated.

Double-bind communication is considered by some theorists to be at the core of the schizophrenic maladaption. The child recieves two opposing messages from the parent. "Come give me a kiss!"..."Oh, I hate you, you got mud all over me."

Using the text and the DSM-III, review the different types of schizophrenia. Briefly, these are 1) schizophrenia disorganized, 2) schizophrenia catatonic, 3) schizophrenia paranoid, 4) schizophrenia undifferentiated, and 4) schizophrenia residual. Schizophrenic clients are also classed as chronic, sub-chronic, or in remission. Schizophrenic patients may also be classified or divided along two other guides. Is the disorder process or reactive schizophrenia? In process the onset is slow and insidious, where in the reactive type the onset is usually rather sudden and in response to a definate stressor. The prognosis for someone who suffers from the reactive type is much more positive than for someone who has the process type of schizophrenia.

237

Schizophrenic patients are classicly disturbed in three areas. There are disturbances of thinking, disturbances of feeling, and social/behavioral disturbances. A disturbance in thinking has generally been considered the primary characteristic of schizophrenia. The patient displays "loose association of thoughts" through his or her verbal patterns. Listening to the speech of a schizophrenic will soon lead the listener to be sure that something is very wrong. When a schizophrenic is speaking, his or her thoughts do not lead logically from one to the next. In normal conversation, we are often able to mentally finish the sentence of someone who is speaking to us. We are able to do this because we know the context in which they are speaking and we are able to rely on one of their thoughts leading to the following logical thought. This is not possible when the speaker is a schizophrenic.

Another example of thought disturbance is "magical thinking". This client believes that his thoughts can control the events around him. When this person tells you to "drop dead!", he thinks that you will. A schizophrenic client may also feel detached from his body and he or she may communicate in a private language...if the client creates new words they are called neologisms. If he or she speaks in an abbreviated manner (only verbalizing every tenth word, for example) this is called cryptic language.

Schizophrenic clients may also present with illusions, delusions, and hallucinations. Make sure that your students are clear on the differences between these three. An illusion is the misinterpretation of a real sensory experience. An example is the experience of seeing the same person at the shopping mall two or three times in the same day. The schizophrenic will assume that they are being followed. A delusion is a fixed belief of the client's that is not responsive to logical reasoning. Someome with a delusion of grandeur may think that they are Jesus Christ. It is very important that the clinician know the cultural background of the client. A delusion is a firm belief that is not in keeping with the person's culture. A hallucination is a false sensory perception. Hearing voices speak to you, when there is no one around and no way that you could be overhearing someone else, is a hallucination.

Another sign of the schizophrenic disorder is disturbances of feeling. A schizophrenic is often referred to as presenting with a "flat, blunted, or inappropriate affect." Affect refers to one's mood. Schizophrenics evidence social and behavioral deficits. They may appear aloof and uninterested in the world and the people around them. One thing that should be kept in mind is that no two clients will present themselves in the same manner.

In general, remind your students that:

1) Schizophrenia usually begins in young adults.
2) The "split" in the word schizophrenia means a split in the relationship of thought, feeling, and action.
3) A person with good family and social relationships is more likely to recover quickly from a schizophrenic episode.
4) There is not a personality type that is more prone to the disorder.

Affective Disorders

As stated earlier, affect means the outward experssion of a mood. Someone who is unhappy will usually have a sad or unhappy affect. Unhappiness that is pathologically intense and or prolonged is called depression. Using the text and the DSM-III, review the criteria of the various affective disorders. Notice how differently the symptoms might be manifested if the client were elderly. In the notes on OBD, we referred to pseudodementia.

239

Pseudodementia is the form that depression may take with an elderly client. Treatment of the depression, in an older client, may result in all of the symptoms of dementia disappearing.

From the text, review the models of depression that are presented. It is interesting to note that left untreated, most depressive episodes will lift after abvout six months. So why bother trying to treat depression? The reason for treating depression is that the major side-effect of depression is suicide. It is very dangerous to ignore the many negative thoughts, utterances, and feelings of a depressed person. Depression is often accompanied by feelings of worthlessness and self-hate. The depressed person's entire being is focused on the inner pain that he or she is feeling. Their very condition makes it impossible for them to consider the pain or loss that they might be causing anyone else by their death.

People who are planning to kill themselves do talk about it. They do plan ahead. Do not deny the client's feelings by shying away from the subject of suicide. You will not put ideas into their head. A discussion may help relieve some of the person's anxiety and give them an opportunity to verbalize the things that they have to live for. It is important for your students to know that a client who is emerging from the depths of a depressive episode is at very high risk of killing themselves. Depression is not just an emotional thing; someone who is depressed is physically depressed, too. When they are beginning to emerge from the depression is when he or she will have the strength to do something that will alleviate their pain, as they see it. They finally have the energy to carry out their plans. In the initial meeting with a severely depressed client, it is imperitive that the staff member know several things. These are:

1) Is the client suicidal? Ask directly, " Are you thinking of killing yourself?"
2) Does the client have a plan? Ask what it is?
3) Does he or she have the means available? Once again, ask direct questions. Most depressed or suicidal people will answer your questions.
4) How lethal is the method?
5) Have they ever attempted suicide before?
6) What method did they use that time?

Older males, who are living alone are at a very high risk of suicide. People with poor social and personal resources, and those who abuse alcohol and drugs are also in the high risk group. CLIENTS WHO HAVE A HISTORY OF MULTIPLE, HIGHLY LETHAL SUICIDE ATTEMPTS AND WHO VERBALIZE A DESIRE TO KILL THEMSELVES IN A SPECIFIC MANNER, ARE AT VERY HIGH RISK AND NEED IMMEDIATE INTERVENTION.

Review with the class what the text has to say about loss and uncomplicated bereavement. Stress to the class members that it is not abnormal for an older person to grieve for a long period of time. Some of the determinants of how long someone might grieve over the loss of a spouse are:

1) Degree and length of attachment to the person who is now dead.
2) Age, health and financial security at time of loss.
3) Extent of support network.
4) Amount of commitment to outside interests.

Some points for class discussion might be attitudes about funerals and wakes. Do they serve a purpose? Have any members of the class noticed a change in the way death is handled during their lifetime? Is death talked about openly in their family? How is death explained to children? Why might it not be a good idea to tell children that someone died because "Jesus loved them," or because "they were so good." Should children be told that dying is

241

like going to sleep? How might they react? Ask your students if they have ever been around someone who was dying? How did they feel? Were they comfortable in talking to the person? Did the dying person attempt to talk about their death? Have they ever known anyone who committed suicide? What were the feelings of the family afterwards? What do the class members think about euthanasia? Should it be legalized for certain groups?

Do the members of the class think that someone's attitude about death might have some effect on how long or intensly they might grieve a loss?

Anxiety Disorders and Personality Disorders

Review with the students the specific criteria for anxiety disorders. Using the DSM-III and the text, look at the different types of anxiety disorders.

According to the DSM-III, personality traits are " enduring patterns of perceiving, relating to, and thinking about one's environment and oneself...It is only when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute personality disorders." Remind the class that personality disorders are life-long patterns of behavior that are maladaptive to the well-being of the client. A person does not develop a personality disorder at age 65. The diagnosis of personality disorder should be made only when the symptoms are characteristic of the person's life long manner of dealing with the world around them, not when they are limited to a discrete period of time. People with a personality disorder are often frustrated with the impact that they have on others. They may appear depressed and anxious, this may be the reason that they seek help.

242

References

Johnson, B.S. (1986). Psychiatric-Mental Health Nursing: Adaptation and Growth, Philadelphia: Lippincott.

PSYCHOPATHOLOGY II

Name: ______________________________ Date: __________________

CIRCLE THE CORRECT ANSWER.

1. What is the most feared of the psychiatric disturbances in the elderly?

   a. Schizophrenia
   b. OBD (Organic Brain Dysfunction)
   c. Major depression

2. In order to rule out degenerative dementia, evidence can be found from:

   a. subjective information
   b. history, physical, laboratory and/or neurological evaluations
   c. statistical data

3. In pseudodementia, the dementia-like symptoms will most likely cease when the depression is treated. However, in dementia, the dementia process will:

   a. continue to deteriorate over time
   b. cease if depression is treated
   c. respond only to medication

4. A significant number of schizophrenics are found in:

   a. suburban neighborhoods
   b. blighted urban areas
   c. rural communities

5. Schizophrenia is characterized by:

   a. depression
   b. interest in the environment
   c. logical thinking disturbances

6. In the elderly, treatment of schizophrenia consists of maintenance doses of psychotropic medications and rehabilitative therapy with an intended goal of:

   a. fostering dependency
   b. living independently
   c. referring for placement due to lack of necessary living skills

7. The elder diagnosed as having a major depressive disorder or a bipolar disorder may:

   a. have an organic disturbance
   b. exhibit agitation and aggressive behaviors
   c. develop illusions and lose contact with reality

8. Grief or uncomplicated bereavement among the elderly is considered:

    a. a normal reaction in response to a real or perceived loss
    b. psychopathological
    c. uncommon when lasting from 3-5 years

9. The most common anxiety disorder in the elderly is:

    a. simple phobia
    b. panic disorders
    c. generalized anxiety disorder

10. Personality disorders in the elderly frequently:

    a. develop after retirement
    b. complicate the clinical picture
    c. respond to treatment

Psychopathology II

1. b
2. b
3. a
4. b
5. c
6. b
7. b
8. a
9. c
10. b

In this section, we have provided some viewgraphs that can be copied as transparencies for use with an overhead projector. Some points to emphasize to students are given.

Most often, alcohol abuse by an older person will be a reaction to stresses and losses that accompany aging. Keep in mind that an elderly person may not require as much alcohol as a younger person does to become intoxicated. Warn students to avoid the pitfalls of labels, like "alcoholic" and "alcoholism" and stereotyped images. Perhaps it is better if we do not worry whether a person is an alcoholic or not. Let's simply concern ourselves with the problems they are having and see if alcohol is a part of that problem. No one wants to label someone as an alcoholic. There are as many definitions of alcoholism as there are people using the term. Having to "admit to being an alcoholic" can be a tremendous barrier to those seeking some help with problems that involve drinking.

Emphasize to students that it is difficult to estimate how widespread alcohol abuse is among older persons. Formal and informal case providers are reluctant to accuse an older person of abusing alcohol, partially because of the social stigma involved. Two additional causes of faulty estimates are the tendency to look for an organic base for the problems of the older person and the difficulty that the elderly have accessing community service programs. We do know that over one third of the calls to one community alcohol referral service related to persons over 55. The older person who begins to drink in response to life stresses is very often hidden from view; therefore, their abuse remains hidden. Discuss the interventions that are outlined in the text.

Very seldom will older clients be found abusing illegal or "street" drugs. Most often their problems will stem from inappropriate use of prescribed or over the counter (OTC) medications. Have the class discuss ways in which these might be misused and the consequences thereof. Review the list of foods that interact with medications. Talk about the possible effects of alcohol in some medications. Remind students that people over 65 consume almost 30% of all prescribed medications. This is understandable when you remind them that the elderly are also more likely to have a chronic illness that requires daily medication. The more medication a person takes each day the greater the risk of some problem arising.

Have the class discuss some of the ways in which medication misuse might be avoided. What can they do to help their clients? Discuss the interventions listed in the text.

SUBSTANCE USE DISORDERS

Name: ______________________________ Date: ________________

CIRCLE THE CORRECT ANSWER.

1. Misuse of alcohol by the elderly is often used as a "self-medication" to:

   a. be accepted by their peers
   b. respond to age related stress and losses
   c. induce sleep

2. The difficulty in identifying alcohol abusers among the elderly stems from:

   a. the tendency of professionals to favor organic bases for problems in later life
   b. the concept of "hidden abuser"
   c. both a and b

3. The "aging alcoholic" can best be defined as:

   a. later life onset abuser
   b. early onset alcohol abuser
   c. occasional drinker (social drinker)

4. Intervention with alcohol abusers must:

   a. include AA (Alcoholics Anonymous) in order to be effective
   b. treat late and early onset abusers the same
   c. use different approaches for long-term versus later-life alcohol abusers.

5. Although the elderly account for approximately 11% of the nation's population, they consume what percent of all prescribed drugs?

   a. 5-10
   b. 15-20
   c. 25-30

6. The substance misuse/abuse disorder can best be addressed by:

   a. intervening only with the patient
   b. using a system related solution
   c. educating only the physician

BEST COPY AVAILABLE

7. One group of medical researchers concluded that a reasonably alert older person cannot expect to:

   a. manage more than three medications without some assistance
   b. be responsible for any self-medications
   c. become disoriented due to medication interaction or misuse

8. Other medical researchers found that:

   a. adverse drug reactions were related to the number of drugs hospital patients consumed
   b. adverse drug reactions were not a concern for hospitalized elderly
   c. the effects of prescription drugs almost never was the basis for admissions to general hospitals

9. Even if the older person takes his/her medications as prescribed, and even if the right amount and kind of medication is prescribed:

   a. improper use of over-the-counter drugs can cause adverse reactions
   b. use of certain foods can cause adverse drug reactions
   c. both a and b

10. Many drugs, vitamins, and food interactions might be avoided through conversations with one's physician, and making one's _______________ a valuable resource in medication information and consumption.

    a. neighbor
    b. spouse
    c. pharmacist

Substance Use Disorders

1. b
2. c
3. b
4. c
5. c
6. b
7. a
8. a
9. c
10. c

BLANK PAGE

Substance Use Disorders

Alan D. Whanger

INTRODUCTION

To many, the stereotype of a person involved in drug abuse is an unkempt and often antisocial young person using a variety of rather exotic substances to achieve some sort of dreamy fantasy state or a "high." It is well that *DSM-III* has changed the terminology to *substance use disorders* to help us broaden our concepts of who uses what for what purpose and with what results, so that we can better understand the nature and extent of this problem in the elderly.[1] Certainly the scope of substance abuse in the elderly has been both underreported and underappreciated. Perhaps some of this stems from the idea that drug abuse primarily involves illegal drugs; also, earlier statistics dealt mainly with narcotics. The relative paucity of known addicts over age 40 was explained in 1962 by Winick, who—after studying the active addict list of the Federal Bureau of Narcotics—noted the disappearance of many addicts between ages 35 and 45.[2] He postulated that addiction was closely related to the teens and twenties, when individuals were struggling with developmental issues of the life cycle, such as aggressiveness, sexuality, and career choices, which predisposed many to drug abuse. He felt that by the late thirties, most of these people would "mature out" by reaching a state of emotional homeostasis and thus would grow to rely less on drugs as a means of coping. This concept was altered by later studies such as that by O'Donnell, who in 1969 did a follow-up study of 266 former patients of the narcotics treatment program of the Lexington Hospital.[3] This study showed that 144 of the former patients had died; 21 were still addicted to narcotics, and a substantial number of the others were addicted to different drugs. Of those addicted, however, only 1 was still on the active addict list kept by the Federal Bureau of Narcotics. The rest were not listed; for some, there was a lack of definite proof of addiction; others had become "medical addicts," being nurtured on legally issued supplies; and some simply were unknown to the bureau.

Another illustrative study of an older addict group was conducted by Capel and Stewart in New Orleans, where a group of 38 narcotics addicts between the ages of 48 and 73 were found who were not involved in any treatment program.[4] They discovered that many of the older addicts do not outgrow their habit; rather, they hide it from official attention by such measures as switching to cheaper narcotics, decreasing their daily doses, or substituting other drugs. These and other studies suggest that there are significant numbers of older typical addicts who often manage to keep their habits hidden.

Most of the substance use disorders of the elderly do not involve illegal drugs, however. The major problems occur in the abuse of so-called recreational and legal drugs or with the misuse of medicinal drugs, prescribed either by the physician or the patient. While the elderly (i.e., those over age 65) of the United States make up only about 11 percent of the population, they receive more than 25 percent of all prescriptions; and over 75 percent of all the elderly regularly use some kind of medication, of which at least a third are obtained over the counter.[5] In a cynical mood long ago, Voltaire said, "A physician is a person who pours drugs of which he knows little into a body of which he knows less."[6] Fortunately, both medicine and practice have improved greatly since then, but as Maddox points out, a major problem still exists in the abuse of older persons by health professionals who prescribe drugs frequently without adequate information, knowledge, or surveillance.[7] The subject of geriatric medicine and physiology is just beginning to be studied and taught seriously.

References to drug use and abuse in the elderly are rather sparse, and they are difficult to summarize or even correlate because of differences in the patient populations and in the definitions and terms used, and because of the fact that many new drugs are only recently available. Some studies lump together those subjects "over age 50" or do not look at those over age 75, and these often tend to ignore or overlook important age-related changes. It is easy to forget that just 30 years ago hardly anybody knew what a tranquilizer was. Yet, as Maddox says: "We live in a society which desperately wants to believe that better living can be achieved through chemistry. Informed individuals are now less confident than they once were that their faith is well placed, but the will to believe is still there."[8] In this chapter we hope to deal with some of these problems and issues in such a way as to help practitioners understand the complexities of drug treatment, use, and abuse in the older people with whom they work, with the goals of both *primum non nocere* (first do no harm) and, indeed, to make life more healthful and gratifying.

NOSOLOGY

Introduction

It is noted in *DSM-III* that the use of substances such as alcohol or caffeine or medically prescribed drugs to modify mood or behavior is generally regarded as normal and appropriate.[9] In distinction are those conditions that are generally viewed as extremely undesirable and are considered mental illnesses, and in which behavioral changes are brought about by the more or less regular use of substances affecting the central nervous system. These disorders are distinguished from the substance-induced organic mental disorders that describe the direct acute or chronic effects on the central nervous system, such as intoxication or withdrawal; and the reader is referred to the chapter on organic mental disorders for further details. Generally, pathologic use is divided into substance abuse and substance dependence.

Substance Abuse

To distinguish substance abuse from nonpathologic use, three criteria are used. First is a pathologic pattern of use, which may involve daily intoxication, including an inability to cut down or stop use even when it may aggravate a serious physical problem; regular use of the substance for adequate functioning; or episodes of complications such as blackouts or overdose. Second is impairment in social or occupational functioning because of the substance use, so that the individual experiences difficulty in meeting obligations to family or friends; this impairment may include such things as displays of aggressive or impulsive behavior, legal difficulties because of accidents or criminal behavior, or inability to function adequately in the everyday affairs of life. Third is duration, with the requirement that the disturbance last at least one month, although signs of the problem may not be continuously present.

Substance Dependence

Substance dependence is more serious than substance abuse, because it involves physiological dependence manifested either by tolerance or withdrawal. Tolerance refers to either the increasing amounts of the substance needed to reach the desired effect or the marked loss of effect with the usual dose. Withdrawal is the substance-specific syndrome that occurs after reduction or cessation of the usual intake. The *DSM-III* does require additional evidence of social impairment or pathologic substance use to support a diagnosis of substance dependence in the cases of alcohol and cannabis (marijuana).

Classes of Substances

In *DSM-III*, there are five classes of substances that can be involved in both abuse and dependence. These major classes include alcohol, barbiturates or similarly acting sedatives or hypnotics, opioids, amphetamines or similarly acting sympathomimetics, and cannabis. Three groups of substances are connected only with abuse, since clearly defined dependence has not been demonstrated. These are cocaine phencyclidine (PCP) or similarly acting compounds, and hallucinogens. Tobacco is included, but it is associated only with dependence. Caffeine may be associated with toxicity. It is recognized that an individual frequently uses several substances simultaneously or in rapid sequence; the listing of each specific substance is encouraged where possible. There is, of course, a category of "other specified substance dependence" to include drugs that cannot be categorized elsewhere.

Classification of Course of Illness

There are general guidelines for subclassifying the course of the illness according to patterns of use. These are: continuous use, with regular maladaptive use for over six months; episodic use, with recurrent circumscribed bouts in the past; and remission, in which the person is not presently using the substance but is felt, because of circumstances, to require continuing evaluation and treatment.

Application to the Elderly

As indicated previously, our concepts of substance use disorders must be modified considerably to make them applicable to older persons. Certain classes of drugs are so rarely used by older persons that they need not be considered here. In their careful survey of elderly substance abusers, Peppers and Stover found that the use of hallucinogens, amphetamines, and inhalants by the elderly is extremely rare.[10] There is a small group of abusers of opioids, but not of cocaine. The situation with cannabis is less clear; Pascarelli observed that many of the older opioid users also continue to use marijuana.[11] Far and away the greatest substance abuse problem is alcoholism, with Schuckit estimating that about 10 percent of the general elderly population have alcohol-related difficulties.[12] The other major problem area for the elderly is drug misuse, a complex issue that is reviewed by Petersen and his colleagues and by Eisdorfer and Basen.[13, 14] It is detailed along with the other significant disorders in the next section.

SYNDROMES—SUM AND SUBSTANCE

Alcoholism

Introduction

Mankind has had a long, intense, and ambivalent involvement with ethanol, a simple alcohol. It has been humanity's main recreational drug and has also been the prescribed treatment for many ills; yet the substance has also caused more personal and societal havoc than all other drugs combined.[15] This involvement has been described as a 5,000-year-old uncontrolled experiment by Mishara and Kastenbaum, who also point out that mankind's earliest legends dealt with old age and alcohol in the Epics of Gilgamesh in ancient Sumeria.[16] The hero attempted to use his courage and intellect to preserve youth against the onslaught of aging and death but was unsuccessful. In this human and cosmic struggle, many of the benevolent and malevolent deities fell in battle with one another, and from their bodies sprang the grapevine. While humanity, personified in Gilgamesh, failed to deter either aging or death, it was given wine or the "blood of the grapes" by the dying gods, perhaps as a solace for the privations of the human condition.

Incidence

The abundant ancient legends, folklore, stories, and teaching about alcohol being what they are, we need to look at the situation in which older Americans now find themselves. About 70 percent of the adult population use alcohol to some extent, although in the elderly this figure may drop into the range of about 50 percent.[17] There are basically two types of older alcohol abusers: those who have been drinking for much of their lives but have managed to survive into old age, and those who began their drinking late in life. As Forni points out, however, even older social drinkers are at increased risk, because of mixing (1) drinking and driving, (2) drinking and other drugs, and (3) even drinking and walking.[18] The exact rate of alcohol abuse is not clear, as there are wide variations in the reported studies; but Schuckit estimates that up to 10 percent of the older population are affected significantly by alcohol problems, while among certain groups the incidence is much higher.[19] He estimates that among the elderly, about 20 percent of medical inpatients and 15 percent of medical outpatients have serious, alcohol-related life problems. Those admitted to psychiatric facilities may have an even higher incidence; Simon reported that 28 percent of all admissions to a geriatric screening unit had serious drinking problems, while Gaitz and Baer reported that of 100 consecutive patients over age 60 admitted to a county psychiatric screening ward, 44 percent were diagnosed as having an alcohol-related disorder.[20, 21]

Pharmacological and Physiological Effects

Alcohol has a variety of pharmacologic effects on the human body, but primarily it is a depressant of the central nervous system. The results of this are generally related to the concentration of alcohol in the blood. As Woolf outlines, alcohol in low doses first depresses the inhibitory areas of the brain, giving the mistaken impression that it is a stimulant.[22] As the reticular formation is involved, behavioral changes take place. The cortex is then involved, and as the dose increases, the depression extends down the brain stem until at lethal dose the medulla is suppressed, causing respiratory arrest. Alcohol decreases the ability to perform mental or motor tasks, but intoxicated individuals may think they are doing better because they have a concomitant impairment of judgment. Some anesthetic properties are present, which may cause the individual to ignore physical or cold injury. Ethyl alcohol has a number of complex effects on the neurotransmitters of the brain, and it has been speculated that it stimulates the production of substances with a morphinelike effect, which may account for alcohol's addictive properties. Alcohol has a profound effect on sleep patterns, so excessive sleep may occur during some levels of intoxication; since it decreases rapid eye movement (REM) sleep, however, there is a REM rebound during withdrawal that results in insomnia. A number of diseases are directly related to biochemical changes induced by the metabolism of sizable quantities of alcohol: fluctuations in blood sugar, ketoacidosis, hyperlipemia, fatty liver, and gout. Alcohol is a direct hepatotoxic substance and can cause reversible fatty liver, alcoholic hepatitis (with a mortality rate of 10 to 30 percent), and cirrhosis. Various vitamin and mineral deficiencies occur in alcohol abuse, both because of limited food intake and through alcohol-related defects in absorption and storage of nutrients. Deficiencies of the B vitamins, in particular, lead to frequent neuropathies, psychoses, and some cardiovascular symptoms. The intestinal tract is markedly inflamed by prolonged alcohol ingestion, and it is often the subsequent vomiting that brings the patient to a physician. Most cases of pancreatitis occur in alcoholics. Even moderate to occasional doses of alcohol can suppress testosterone levels, and continued abuse causes an increase in estrogen levels, creating some feminization in males. Heavy alcohol intake also has a variety of effects on the cardiovascular system, including hypertension, cardiomyopathy with heart failure, irregularities in cardiac rhythm, and rapid heat loss because of vasodilation. The activity of white blood cells is impaired by alcohol, so resistance to infections such as pneumonia and tuberculosis is lowered by alcoholism.

Clinical Problems

The elderly alcohol user or abuser may come to health care professionals because of a variety of problems in a variety of circumstances. Many will present with some type of alcohol organic mental disorder, as described in *DSM-III*.[23] Simple alcohol intoxication will probably show up only if there are severe maladaptive behavioral effects, such as fighting, suicide attempts, or injuries. The length of intoxication is largely dependent on the amount ingested, since there is a relatively constant rate of metabolism—about 5 to 10 cc. per hour. There is considerable variation in individual susceptibility to intoxication. Some people show signs of it with blood alcohol levels as low as 30 mg. percent, while others may show no toxicity with levels at 150 mg. percent. The elderly are often more sensitive to the effects of alcohol, especially if there has been previous brain damage or the use of other drugs.[24] A diagnosis of intoxication is indicated when there is a history of recent alcohol intake with at least one sign of physiological changes, such as slurred speech, incoordination, nystagmus, or facial flushing; and at least one psychological sign, such as mood change, irritability, talkativeness, or impaired attention. A few individuals respond to very small amounts of alcohol with a marked reaction that has been called pathological intoxication or idiosyncratic intoxication. Those with cerebral damage or other debilitating illness are more likely to have a low tolerance for alcohol, making it more likely that the older drinkers' thinking processes will be more susceptible to the effects of alcohol than those of younger drinkers, as mentioned by Eckardt.[25]

Alcohol withdrawal usually occurs within several hours after cessation of drinking in an alcohol-dependent person who has been drinking for several days or longer. In an older person with previous withdrawal problems, this may often occur after only three or four days of heavy drinking. The principal features are a coarse tremor of the hands, tongue, or eyelids and associated symptoms such as nausea and vomiting; malaise; autonomic hyperactivity with rapid pulse, sweating, or increased blood pressure; anxiety; depression or irritability; or postural hypotension. Sleep is often fitful, with disturbing dreams that sometimes merge into illusions or poorly formed hallucinations. The withdrawal symptoms are usually over in five to seven days, but a number of elderly alcohol abusers have been noted to take two to three weeks to recuperate from a serious drinking bout.

Some may go on to more severe problems, such as alcohol withdrawal delirium, which used to be called delirium tremens or the D.T.'s. This usually begins on the second or third day after cessation of drinking, but it can occur as late as the tenth day in older alcoholics. It may be heralded by a grand mal seizure, or it may be characterized by vivid, delirious hallucinations of a visual or sensory modality and by confusion. If treated promptly and properly, it will have run its course in two or three days; untreated, it may have a mortality of up to 15 percent.

Some may develop varied auditory hallucinations, usually within 48 hours of withdrawal. They tend to be unpleasant and disturbing and are often of voices discussing the patient; they occur in an otherwise clear sensorium, however. Most of these symptoms are over within a week, but some may persist for weeks or months. They may even develop into a chronic form, especially if there have been repeated bouts of this disorder.

In some people an alcohol amnesia disorder develops after an episode of Wernicke's encephalopathy, which involves confusion, staggering gait, eye-movement problems, or other neurologic signs. The disorder is related to vitamin deficiencies, especially of thiamine, and is manifested by memory deficits. It is also known as Korsakoff's disease, and it usually persists indefinitely.

After prolonged alcohol abuse, the individual may develop varying degrees of dementia that may be profound and permanent. Gaitz and Baer noted that of their elderly alcohol abusers who were admitted, 29 of 44 (66 percent) had evidence of organic mental syndrome (OMS).[26] Those with OMS tended to be males and to be much younger than unaffected patients (65 years for those with OMS; 73 years for those who had no OMS).

It is important to keep in mind that various withdrawal problems may arise unexpectedly in secretly alcohol-dependent people who are admitted to the hospital for acute medical or surgical problems. A sudden change in behavior or onset of withdrawal-type symptoms two or three days after admission, by which time patients have been acutely deprived of their alcohol source, should prompt rapid consultation and investigation, and often treatment for withdrawal states.

Assessment and Diagnosis

If the patient has a history of alcohol abuse, the health professional will be more likely to suspect and detect an alcohol-associated disorder. As many elderly people and their families tend to hide drug-related problems, a number of cases will be overlooked until unexpected withdrawal reactions or peculiar physical problems arouse suspicion or even create gross awareness of an underlying alcohol abuse problem. Some elderly people have the notion that drinking beer or wine instead of "hard stuff" will prevent them from getting alcohol-related problems. In the acute phase, a blood alcohol level may be helpful, but this will be of little value in most cases with the elderly.

A good general physical examination will pick up various signs, such as tremors, alcohol on the breath, an enlarged liver, or red palms, that are suggestive of an alcohol-related problem. Useful biochemical tests include those that check blood sugar, liver function, electrolytes, serum magnesium level (which is often low in chronic alcohol abuse), serum proteins, and folic acid levels. An electrocardiogram might show cardiomyopathy. The electroencephalogram may provide an indication of diffuse brain damage or evidence of a subdural hematoma (blood clot on the brain); such is certainly a good possibility in older persons, who are more susceptible to falls because of the alcohol use but less inclined to remember having fallen. They also have more fragile blood vessels than younger people.

The National Council on Alcoholism has developed criteria for early recognition of alcoholism.[27] Many of these have already been covered, but other things to look for include morning shakes, which may indicate a withdrawal reaction even after the brief abstinence that occurs during sleep. The person will often drink an "eye-opener" shortly after arising. Tolerance to alcohol may be expected in someone who consumes large quantities of alcohol without becoming noticeably intoxicated. Blackouts in which the person seemed to be functioning normally but cannot remember, or only vaguely remembers, what he or she did are highly indicative of alcohol dependence. A person who drinks in spite of strong medical, social, or psychological contraindications should certainly be considered a potential alcohol abuser. A useful six-point scale of the degree of alcohol abuse based on such characteristics was developed by Zimberg.[28]

The complex interaction of alcohol with other drugs used by the elderly makes their problems both more severe and less clear. Alcohol interacts with more than 150 commonly prescribed drugs, as described by Hartford and Samorajski.[29] This subject is covered in more detail later. Acute alcohol intake impairs breakdown by the liver of many drugs, such as chloral hydrate and barbiturates, and so potentiates the effects of these and other drugs. Chronic alcohol use, on the other hand, increases the metabolism of other drugs, necessitating higher dosages. Some drugs used by older persons, such as the tricyclic antidepressants and the major and minor tranquilizers, may increase the response to alcohol markedly, so older people should be cautioned not to use these drugs and alcohol simultaneously.

Epidemiology

There have been several reports on epidemiological issues related to alcohol abuse in the elderly. While the results of different studies are somewhat disparate, some of them will be cited to help explain the problem. About two-thirds of the people with alcohol use disorders began drinking heavily earlier in life, and about one-third are late-life-onset drinkers. A number of reports are summarized by Petersen and Whittington.[30] The younger-onset drinkers tend to drink more. Alcohol-related disorders have a tendency to peak in the 35- to 50-year-old age group, but a second peak occurs among people 65 to 74 years of age. Alcohol abuse tends to be a male-dominated practice, with about two out of three involved being males. Generally, the earlier the onset of significant drinking, the more likely it is to have associated physical problems and the less likely to have a good treatment outcome. Fewer of the late-onset males fit the criteria for personality disorders or report the use of illicit drugs than those who have early-onset alcohol problems.[31] Drinking patterns in the two groups tend to differ, with the late-onset drinkers more likely to drink daily but drinking less (four drinks) per occasion. The late-onset alcoholic is more likely to enter treatment voluntarily and to stay there. Most people with late-life-onset alcohol problems are white. A study by Meyers and his group in Boston did not find clear evidence of late-life-onset drinking problems and found no significant relationship between problem drinking in old age and marital status, household composition, or employment status.[32] They did find that those with alcohol-related problems (ARP) were less satisfied with their lives in general and in specific life areas. A small but interesting study was done by Dunham, who found six life patterns of drinking that showed rising and falling alcohol use over the life span.[33] In his group he found that 68 percent were lifelong abstainers, and these were more likely to be female, married, Latin, and Catholic. Four of the drinking patterns were problematic for the elderly: the "rise-and-sustained" pattern of a heavy drinker, who continues heavy drinking into old age; the pattern of a "light-and-late-riser," whose light drinking rose to moderate levels in old age; the "late starting" pattern, with onset of drinking late in life; and the "highly variable" pattern, with episodic heavy drinking. He did believe that certain types of people characteristically fell into different patterns with various types of problems and needs for treatment, but the study needs replication.

Treatment

Treatment of the elderly person with an alcohol problem has a potentially large number of variables, so precise instructions cannot be given. Early intervention is an ideal, but the health professional often has little opportunity for this, since—as Mendelson and Mello point out—even the disease conceptualization of alcohol abuse involves a complex interaction between the person, the pharmacologic properties of alcohol, and the general social and environmental context of the individual.[34] Thus, the patient may not be available until the situation has progressed enough either to reveal the problem or force the issue. As with younger patients, the family must accept the problem and the patient must be confronted with it, as the customary patient denial is often fostered by the family's acceptance of that denial.[35] Treatment generally falls into four overlapping but sequential phases, as suggested by Blume: the identification/intervention phase, the detoxification phase, the rehabilitative phase, and the long-term follow-up.[36] As Pattison indicates, alcohol problems are varied and complex, so treatment programs must be reasonable and selective.[37] For the elderly, hospitalization or other institutionalized care (such as in a detoxification center) should be considered for anything more complicated than simple intoxication, as many elderly alcohol abusers are malnourished and have multiple medical problems.

The cornerstone of treatment of alcohol withdrawal syndromes is the use of a drug with depressant properties similar to those of alcohol—followed by the gradual withdrawal of the drug—along with good medical, nursing, and nutritional care. The drug usually prescribed for this is chlordiazepoxide (Librium), because of its relatively long half-life and it's cross tolerance with alcohol.[38] A useful set of guidelines is given by Mayfield.[39] First, if there are obvious signs of alcohol intoxication but no emergency otherwise, wait for the signs of intoxication to clear before beginning other drugs. If there is no history of previous withdrawal problems such as the shakes or D.T.'s, and no present signs, one may observe closely and begin medication at the first such signs. If withdrawal signs are not present but are expected or have occurred previously, begin chlordiazepoxide at 25 mg. every 6 hours. If no signs appear over three days, the medication can be tapered and stopped. If signs do appear, the medication should be increased to 50 mg. every 6 hours for one to two days, then tapered over two to four days. Should withdrawal signs continue, give 50 mg. of chlordiazepoxide every 6 hours, and continue or increase the dosage until the patient has been stabilized for 24 to 36 hours, at which time the drug can be tapered over four days. Should an alcohol withdrawal delirium occur, a rather hazardous condition exists, since this may be associated with seizures, hyperthermia, and cardiac irregularities, as described by Simon.[40] This state can be managed by giving 50 to 200 mg. chlordiazepoxide every 6 hours as needed to achieve sedation to allow sleep but still permit the patient to be awakened. The dosage should be maintained until the delirium has cleared, then gradually be reduced over five to seven days. Valium and other benzodiazepines can be used for withdrawal in comparable doses as well, but close monitoring is essential in the elderly. The patient's fluid and electrolyte situation must be watched carefully. The serum magnesium should be checked as well, since it is often low in alcoholic states and may need supplementation. Vitamin supplements are important, especially the B complex group. It is well to check the patient's folic acid level, as it, too, is often low in those with chronic alcohol problems and may need special supplementation. General malnutrition is common in elderly people with alcohol problems, and the services of a dietitian are often helpful.

Mood disorders are common in alcohol abuse; most are depressive but some are manic. Lithium carbonate has been used when mania is present, but the toxic dose range is uncomfortably close to the therapeutic range in the elderly.[41] Some have advocated progressive tapering of the alcohol level for withdrawal, but Becker feels this to be both psychologically and metabolically undesirable.[42] Paraldehyde has been used for many years, but more adverse reactions have occurred with that than with the benzodiazepine derivatives. Disulfiram (Antabuse) has no place in treatment of the acute withdrawal phase and is generally not necessary (and probably not desirable) in the chronic treatment of alcohol abuse in the elderly, since the effects of adverse reactions may be very severe.

Course of Illness

The rehabilitative phase, of course, plays a substantial part in whether the individual will move to recovery or lapse back into the use of alcohol or some other drug. As Pattison points out, there are no distinct categories of alcohol abusers; rather, degrees of alcohol use are complexly interwoven with other psychosocial variables.[43] A variety of treatment systems exist, and the therapist needs to know which of these are available and which would best suit the needs of each patient. Facilities offer a system of treatment programs that can involve such things as a detoxification center, an information center, a mental hospital, a halfway house, the legal system, the vocational rehabilitation system, psychiatric and medical outpatient clinics, and such groups as Alcoholics Anonymous. Generally, it is important to have family members involved in counseling programs as well, or in such groups as Al-Anon. Patients' goals in such programs are to augment their motivation for change, to understand themselves better, to gain an understanding of the disease, and to develop new ways of handling problems. Zimberg noted that environmental manipulation, medical services, day hospital care, home visiting, and social interactions were most effective in eliminating alcohol abuse among elderly patients.[44] A very low dose of antidepressant, such as 25 mg. of doxepin at bedtime, has frequently been used on a long-term basis to help stabilize the dysphoria and anxiety that are often present and also to serve as a bridge between therapist and patient. A medication may symbolize a relationship between the two, as well as providing a rationale for not drinking and for returning for follow-up treatment. It is important not to give the patient the impression that regular use of some drug is needed to get along, and thus run the risk of the abuse of some other drug.

Course of Alcoholism

It is difficult to generalize about the course of alcohol abuse in the elderly since there are so many variables involved. The presence of physical disease can cause increased pathology from the adverse effects of alcohol in any organ system. As cited by Schuckit and Pastor, those who develop an alcoholic life style prior to age 40 have a very high premature death rate, tending to die 10 to 15 years before their expected life span is over.[45] Older alcoholic men show an elevated rate of medical problems, complicated by the fact that many also smoke.[46] As already mentioned, among older alcoholics who were admitted to a hospital, Gaitz and Baer noted an incidence of about 66 percent with organic mental syndrome (OMS).[47] These individuals tended to be younger than those with OMS without a history of alcohol abuse, and they died at a significantly younger age. This is probably related to the observations of Blusewicz and his group that alcohol abuse causes damage related to sensorimotor functions, auditory and visual perception, short-term memory, and abstract reasoning; thus, "premature aging" is evident.[48] About one-third of older alcoholics presenting for treatment live alone; about 85 percent are white males, according to Schuckit and Pastor.[49] The incidence of suicide in elderly alcohol abusers is not clear, but certainly they are at high risk for self-destruction of some type. Among those who survive into their seventies, a number will be able to stop their drinking or reduce it.

Sedative or Hypnotic Abuse

The term *sedative* is an old one used for drugs that calm anxiety and decrease wakefulness, while a *hypnotic* produces drowsiness or induces a sleep-like state.[50] It was in 1903 that the first barbiturate was introduced, and various derivatives dominated the sedative and hypnotic market until the introduction in 1961 of the first "minor" tranquilizer, chlordiazepoxide (Librium). There are a variety of hypnotics, but most of the older ones are barbiturates, such as pentobarbital (Nembutal) or secobarbital (Seconal). More recently a variety of hypnotic drugs have appeared, such as glutethimide (Doriden), methyprylon (Noludar), and methaqualone (Quaalude). All of these drugs are potentially habit-forming, and so could be or have been abused as street drugs. The literature, which is very limited, shows that the illegal abuse of these substances in the elderly is very rare. A study by Peppers and Stover showed that among the elderly involved in a statewide program for detecting substance abuse, 96 percent were affected by alcohol while only about 1.3 percent were involved in illegal drug use, with 0.2 percent having barbiturate abuse as a primary problem; 0.3 percent, abuse of other sedatives; and 0.4 percent, marijuana-hashish abuse.[51] Many of these substances are illegally abused so infrequently by older patients because they are legally misused so frequently. This problem is discussed later in the section on prescribed drug misuse.

Opioid Abuse

Of the older illicit substance abusers identified in the Peppers and Stover studies, only 0.3 percent had heroin or other opiate abuse as the primary

BEST COPY AVAILABLE

problem. As Cohen points out, there are basically three types of older opioid abusers: surviving street addicts, medical addicts, and what he calls the "Southern-type" addicts.[52] Previously it was thought that the outcome for an older addict was either death or outgrowing the habit. Many surviving opioid addicts continue in their drug-taking habits, as noted by Capel and his group.[53, 54] Generally they assume a very low profile, however, by switching to cheaper narcotics than heroin and by alternating them with codeine cough syrup, paregoric, alcohol, or barbiturates as necessary. A small but increasing number of these people are enrolling in methadone maintenance clinics. There are some ethnic groups with relatively high numbers of elderly opiate addicts, such as the Chinese population in some large cities, as described by Deely and her group.[55] The reasons given by these elderly addicts for their initiation of drug use were peer pressure, curiosity, and availability. These are still major factors among young substance abusers. We can expect a rapidly increasing number of elderly addicts as the present groups grow older; Pascarelli and Fischer predict a potential twentyfold increase over two decades.[56]

The "Southern-type" addict belongs to a group of elderly people who got involved with narcotics long ago, when opiates were much more available than they are today in patent medicines, cough syrups, and paregoric. These persons—generally middle- and upper-class women from small towns—have been maintained by receiving ongoing prescriptions from sympathetic doctors. This practice was predominantly a Southern rural phenomenon. It is, of course, dying out through attrition and changed regulations on drugs.

Another small but distinct group of older opiate addicts are physicians and other medical personnel who have had easy access to these drugs over a period of years.

Misuse of Legal Drugs by the Elderly

The other major area of concern in geriatric substance use disorders is the misuse of legally prescribed drugs. By definition of the federal Strategy Council on Drug Abuse, drug *misuse* is the inappropriate use of drugs intended for therapeutic purposes, whereas drug *abuse* is the nontherapeutic use of any psychoactive substance such that it adversely affects some aspect of the user's life.[57] Pascarelli points out that misuse of drugs can mean not only overuse but also underuse, erratic use, or use in unnecessary or contraindicated circumstances.[58] The three principal areas of misuse of legal drugs are (1) the misuse of prescribed drugs, (2) the misuse of over-the-counter drugs, and (3) iatrogenic or physician-related problems. These are examined in detail.

Incidence

The frequency of drug misuse has, of course, a considerable correlation with the frequency of drug use, especially in the elderly. Studies are scant, however, and often hard to compare with each other. One study of a community population by Chien, Townsend, and Ross-Townsend showed that only 8 percent of this population were medication free; the mean number of drugs taken per interviewee was 3.8.[59] Of this group, 83 percent were taking at least 2 drugs and 15 percent were on between 7 and 15 different drugs. Of psychotropic drugs being taken, 22.3 percent were antianxiety agents, 12 percent were hypnotics, 4.1 percent were antipsychotics, and 2.5 percent were antidepressants. Of great significance was the fact that 33.1 percent of those on drugs were taking one or more medications they could not identify. Of the identified medications, 60 percent were prescribed and 40 percent were over-the-counter (OTC) preparations. Of the OTC group, 26 percent were self-prescribed, 11 percent had been suggested by a doctor, and 3 percent were suggested by a friend or relative. A study by Guttman of community elderly in Washington, D.C., in 1977 showed that 17.4 percent were known to be taking psychotropic medication and 55 percent were on OTC drugs.[60] Studies at Duke University have shown that among the elderly of Durham County, North Carolina, 28 percent of those in the community were on psychoactive preparations, while 65 percent of those living in extended care facilities or institutions were taking such substances. A study of community elderly in Michigan reported by Solomon and Weiner showed that none were "drug free," with 71 percent using prescription drugs, 54 percent using OTC preparations, and 20 percent using home remedies.[61] One-third of those interviewed indicated that they saved their old unused medicines, feeling they might need them again.

Of course, the prevalence of multiple drugs and psychoactive compounds does not necesarily mean that misuse is taking place. The study by Chien and associates also looked at the incidence of symptoms and illness.[62] Only 2.5 percent of their sample reported no illness, and the mean number of illnesses were in four body systems. When they correlated drug use with disease or symptoms, they found that irrational usage (misuse) due to misunderstanding the indications for use of the drugs occurred in only 14 percent overall.

In his study of the Washington group, Guttmann looked at many variables and reached a number of important conclusions.[63] He found that almost all (98.7 percent) of the users of psychoactive drugs got their drugs from physicians, that 50.7 percent felt they could not perform their regular daily activities without the drug, that they were knowledgeable about what the psychotropic drugs were supposed to do, and that most (76 percent) consulted their physician before taking other drugs as well. This group of psychoactive drug users had a significantly higher rate of combining multiple drugs, including alcohol, than the users of all other drugs in general. Males tended to use more alcohol than OTC drugs, and women had the opposite pattern.

The OARS study of the institutionalized elderly (introduced in Chapter 2) showed that 71 percent of them were impaired from a mental health standpoint in contrast to 13 percent of the community group, obviously indicating the need for a much higher level of psychoactive drug use.[64]

The frequency of adverse drug reactions is a rough measure of drug misuse, and some studies give an indication of that. Drug-induced illness may be the major contributing cause of hospitalization in from 5 to 30 percent of all those over age 65, compared to only 2 to 8 percent in the general population, as noted by Williamson and Chopin.[65] Inside a hospital, the likelihood of experiencing an adverse drug reaction is a direct function of age. Hurwitz showed that only 3 percent of those between ages 20 and 29 may have adverse reactions, while 10.7 percent of those between 60 and 69 and 21.3 percent of those between 70 and 79 may have problems.[66] Of the elderly living at home, up to 25 percent may complain of side effects of drugs, according to Eberhardt and Robinson.[67]

Pharmacology and Physiology

It must be emphasized that adverse reactions do not necessarily mean drug misuse, since hardly any physician, pharmacist, or patient would want a bad reaction to occur. A number of physiological factors common in older persons predispose them to drug-related difficulties, and they are well detailed by Friesen.[68] Age-related changes that occur in organ systems of the body, such as the kidneys and liver of the digestive system, make it much more difficult for older people to metabolize and excrete various drugs. Changes also occur in the rate and extent of absorption, in the distribution of the drug in plasma and fat, and in the responsiveness of target tissues. The effects in the body of various diseases, or of the drugs to treat them, create wide and often unpredictable variations in drug response.[69] The nutritional status of the elderly, which is more likely to be inadequate in the ill, has a considerable effect on drug effects and the person's response.[70] Our ability to detect and understand these complex conditions is still very limited, so the response of any particular older individual to a drug is still often unpredictable.

Misuse of Prescription Drugs

The clinical effects of misuse vary widely depending on the drug, the pathology, and the person.

The obvious problem is overuse, which may result in the previously described problems of substance-induced, acute or chronic organic mental disorder or in disorders of abuse or dependence. The addiction potential varies with the drug used and with the frequency and mode of use. Narcotics have a generally high addiction potential, but this well-known property, combined with the fact that many elderly people are relatively intolerant of them, reduces the habituation problem somewhat. Narcotics certainly may cause sedation, confusion, nausea, hallucinations, and nightmares. Probably the most commonly misused drug of this group is propoxyphene (Darvon), which has been cited as the agent in about 10 percent of acute toxic drug reactions in older people.[71] Propoxyphene presents a special problem in that it is one of the most frequently prescribed analgesics for the elderly, and a mild dependency state can develop.[72] There is question, moreover, about whether it has any analgesic superiority over aspirin.[73] Most acute drug reactions in older people are caused by overuse of prescribed drugs. The most commonly misused ones are diazepam (Valium), secobarbital (Seconal), amobarbital (Tuinal), phenobarbital, and propoxyphene. Barbiturates are generally poorly tolerated in the elderly, with oversedation, confusion, and dependence occurring easily. Although barbiturates should rarely be used with older patients, these drugs are still widely prescribed for this group.

Some, such as Pascarelli, felt that antidepressant drugs are potential drugs of abuse, especially amitriptyline (Elavil), which may cause euphoria and then mild withdrawal symptoms on abrupt cessation.[74]

Probably a greater problem than overuse is misuse related to noncompliance. There is a rapidly growing literature on this problem, the importance of which is suggested by the "1975 United States National Institute on Drug Abuse" study, which indicated that between 25 and 60 percent of elderly patients make errors in self-administration of prescribed medications.[75] One report indicated that 30 percent had stopped medication earlier than directed, 20 percent had not filled the prescription, and 14 percent had varied the prescription dose. The frequency of noncompliance is directly related to age, as found by Brand and his associates, who noted rates of 26 percent for those in their forties, 46 percent in their seventies, and 62 percent for patients in their eighties.[76] They found positive correlations between noncompliance and low income, single status, lack of education, and taking several prescriptions. Another study by Schwartz and her group indicated that the errors were in omission (47 percent), inaccurate information (20 percent), erratic self-medication (17 percent), incorrect dose (10 percent), and incorrect timing (4 percent).[77] An interesting study done in Finland found that misuse of prescription drugs reached a rate of about 50 percent and was related to the number and nature of drugs, with underuse and self-adjustment being the major problems.[78] Those drugs most likely to be underused were those used mainly for symptomatic relief rather than cure, those with side effects, those the patient felt were no longer needed, and those that were most expensive. Prescription drugs related to sleep, appetite, and mood were most likely to be overused.

A number of factors conducive to the misuse of drugs by elderly people were identified by Gollub.[79] These were drug overdoses either through error or emotional disturbance, misuse resulting from organic mental disorder, use of multiple prescriptions without the doctor's knowledge, overuse of prescriptions by improper use of automatic or telephone refills, exchange of drugs with others, and use of outdated drugs. In another study, Cooper and his group found that intentional nonadherence to a drug program was more likely to occur when the patient used two or more physicians and pharmacies.[80]

Misuse of Over-the-Counter (OTC) Drugs

Self-medication is supposed to be only for the treatment of minor and self-limiting ailments, but following the advertisements for these multitudinous drugs could make self-medication a national obsession. As Moore indicates, any drug can be abused, whatever its pharmacologic properties.[81] There are four groups of OTC drugs, however, that have been associated with psychoactive properties: sedatives, cold and cough products, analgesics, and appetite suppressants.

Many elderly have, or complain of, sleep disorders, and OTC hypnotics are used by about 23 percent of those using drugs to treat this problem. Until 1979, these preparations contained scopolamine and sometimes bromides, both of which were notorious for producing nervous system toxicity among the elderly. Now they all contain antihistamines, which have a sedative side effect. While these are much safer, they still have significant anticholinergic effects and may produce confusion if they are overused or added to other anticholinergic drugs the individual might be taking. Additional side effects of weakness, heaviness, or paradoxical insomnia may develop.

Most cold and cough preparations contain several ingredients, including an antihistamine, a decongestant, a cough suppressant, and alcohol (often up to 25 percent of content). While these preparations do not usually create trouble, the older person taking them may have problems either with sedation or overstimulation. The preparations certainly potentiate other psychoactive drugs the patient may be using.

Analgesics generally contain salicylates or acetaminophen, often in combination with caffeine. In high doses, salicylates may produce both an acute and chronic toxicity resembling alcohol inebriation. Some elderly people develop an allergy or intolerance to aspirin.

number of drugs increases, a sharp increase occurs in the possible combinations of two drugs that might interact. For instance, if a patient is receiving 7 drugs concurrently, there are 21 different possible interactions; and if a patient is receiving 10 drugs there are 45 different possible combinations. Not all interactions are toxic; some result in a loss of efficacy instead. When using a rational combination of drugs, physicians must be aware of the potential drug interactions. They must adjust doses accordingly and must maintain a high level of vigilance during treatment in order to deal with problems so that older patients will receive the best care possible. Interestingly, Prien and his group found that the proportion of hospitalized psychiatric patients receiving two or more psychoactive agents decreased from 26 percent for those aged 60 to 65 years to 12 percent of those over age 75.[86] Substantially more women than men received multiple psychoactive agents.

Overmedication has been a significant problem for the elderly, especially those who have been institutionalized. A study reported by Prentice in 1970 showed that of the 10 drugs most prescribed in nursing homes, 9 were psychoactive agents.[87] The issue of using medicine, perhaps unnecessarily, to control patients has, of course, been raised. Certainly there have been abuses, but it must be remembered that most of the patients in nursing homes do have major psychiatric problems, as our studies among the institutionalized elderly here have shown. A study by Zawadski of psychotropic drug use among the institutionalized and noninstitutionalized aged showed, however, that the amount spent on prescription drugs for an institutionalized older person was more than twice as much as for the noninstitutionalized.[88] Most of this increased cost went for psychoactive drugs; the institutionalized aged had 17 times more expenditures on psychotropic drugs than the noninstitutionalized, including an impaired group in a community day-care program.

Caffeine

While low on the list of dangers to the elderly as a drug of abuse, caffeine may nevertheless create some problems. It is a central nervous system stimulant that is widely used in drinks and OTC medications. A dose of 200 mg. (the equivalent of two cups of coffee) will produce definite cortical arousal, which may produce insomnia. In susceptible people, it may produce irritability and anxiety, and many elderly become increasingly sensitive to it. Chien and associates report that nearly a third of the people studied drank four to six cups of coffee a day.[89] Checking and advising on caffeine intake may help the therapist reduce an older person's tension and anxiety considerably without the use of any psychoactive drugs.

While most elderly do not share the preoccupation with weight that fascinates the young, those who do have the appetite suppressants available. The OTC preparations generally contain the stimulant phenylpropanolamine and caffeine. Use of such preparations may produce irritability, insomnia, apprehension, and even psychosis.

Iatrogenic Problems

The problem of drug misuse includes the health professionals in various ways. Four factors were identified by Gollub: inaccurate diagnosis; inaccuracies in drug treatment; polypharmacy, leading to drug interactions; and overmedication or arbitrary medication.[52]

A fundamental principle of medicine is to establish as accurate a diagnosis as possible to serve as the basis for the therapeutic plan. The elderly are by far the most difficult group to diagnose accurately, both because they have multiple problems with atypical presentations and also because most physicians have not been trained in geriatrics. Both geriatric medicine and psychiatry are almost new fields in American medicine, but some knowledge of both these areas is important since almost two-thirds of elderly medical patients have psychiatric illness and vice versa.[53] Failing to diagnose problems correctly may result in inadequate drug treatment or placement in the wrong facility, both of which tend to create poor results for the patient and increased stress on the staff. A team approach, such as that in the OARS program, helps to achieve a more accurate total assessment because of the multiple inputs involved, as well as the wide range of therapeutic possibilities provided.

Inaccuracies in drug treatment may be related to incorrect diagnosis, but may also be a result of failing to take into account the age-related alterations in an individual's response to medications. The body's capacity to maintain biochemical homeostasis is reduced with age, leading to more frequent side effects and toxicity. Neither specific doses nor simple guidelines for treatment of the elderly have been established for most drugs, but a number of books and publications are coming out now.[54] A listing of the usual geriatric doses of many psychoactive drugs appears in Appendix B of this volume.

The use of multiple drugs among the elderly is widespread, and it creates a major area for misadventure and misuse. Studies have previously been cited indicating the relatively high frequency of polypharmacy in the elderly, as well as the frequency of side effects and interactions. A drug interaction is not the same as a contraindicated combination where there is a known problem or risk. As Blaschke points out, multiple drug therapy is often necessary in the elderly, and sicker patients often require more drugs anyway.[55] As the

FACTORS IN ETIOLOGY AND TREATMENT

It should be evident that substance abuse in the elderly is a very complex issue, both to understand and to treat. In an interesting study in Durham, North Carolina, Back and Sullivan looked at the relationship between self-image, medicine, and drug use.[90] They found that drug use among women was significantly correlated with three factors: insecurity, sick role, and, curiously, the fear of medicines. The relationship in men was much less clear, but still they concluded that some people are psychologically predisposed to the heavy use of drugs and some, conversely, to the avoidance of drugs. This predisposition may affect the extent of drug use or misuse, perhaps regardless of the level of health or other obvious influences. A study by Hochhauser led him to believe that substance abuse is related to learned helplessness, including a sense of the loss of control, which is essential to successful coping.[91] He speculated that drugs, notably alcohol, may restore a sense of personal control or power and thus reduce anxiety and distress while giving a predictable pleasurable effect. Thus, the extent to which the elderly believe that they can predict and/or control environmental events will have important effects on their levels of substance use, misuse, and abuse.

Treatment is complex, dealing both with immediate problems of intoxication or withdrawal from drugs and also with developing long-range plans to reduce the ignorance and stresses that surround and perpetuate the problem. Help is needed both for the care givers—to improve their knowledge of the proper use of therapeutic substances—and for the patients—to help them utilize medications in a safe, proper, and healthful way.

CASE STUDY—A COMPLICATED CASE OF ALCOHOLISM IN AN OLDER MAN

Present Illness

Dr. B. is a 70-year-old, white, retired obstetrician who was referred to the OARS-GET Clinic by his psychiatrist from a medium-sized city in an adjoining state for long-term follow-up care. He had recently been hospitalized in that city because of a recurrent depression that had required a course of electroconvulsive therapy (ECT). He had become increasingly despondent prior to that admission and was very restless, with a poor sleep pattern. Several antidepressants had been prescribed for him without much positive effect, and he complained of increasing difficulty in concentrating and of loss of his ability to function. Increasingly he had become suicidal, and he finally handed his wife a large bottle of barbiturates that he had hidden away. He was fearful that he would indeed commit suicide, either by overdosing or by hanging himself, so he turned to his wife, who then got him in touch with his psychiatrist again.

He first sought psychiatric help eight years before, when he had become suicidally depressed. He required hospitalization at that time. Fourteen years ago, while intoxicated, he had an automobile accident in which his left arm was injured; a woman in the car he struck was rather seriously injured. Following that, he curtailed his practice moderately. Then 10 years ago he decided to retire from practice after a mild heart attack. He had some tension and angina on exertion and began to drink some sherry two or three times a day to help him relax. His wife reported that he progressively became more socially withdrawn and would sit in his study for long periods of time, slowly going through old books and medical journals. About four months prior to his first admission, his wife had a hysterectomy for a precancerous lesion. While she had a good recovery, his already faltering sexual performance failed completely, and he referred to himself as "washed out."

At that time he was hospitalized for about three and a half months, during which three different antidepressants were tried and he underwent psychotherapy. A gradual but fairly good improvement occurred, and he was followed by his psychiatrist for about two years on an outpatient basis on decreasing medication. He and his wife again became more socially active with a small group of old friends, and his wife said that he began "being his old self" again, meaning that he was rather outgoing, talkative, and argumentative. Then he began to try to write an article on the philosophy of obstetrics, an idea he had been talking about periodically for a number of years, but this work progressed very slowly.

About two years before the most recent admission, he began to get despondent and withdrawn again. This state progressed over three months to the point of his being suicidal. Again he was hospitalized, and a course of nine ECT treatments were given; results were good for approximately one year, until his present episode.

His wife, Mrs. B., who is retired from teaching music at a small college in the city in which they live, was becoming increasingly upset and depressed over the situation, and his psychiatrist felt that she should get some type of therapy for herself. As both of them are well known locally, the B.'s expressed a wish to get therapy in another city. For that reason, as well as to get another opinion on Dr. B., they were referred to us.

Psychiatric History

The patient considered himself rather normal from an emotional standpoint until his depression eight years ago, although he admitted that he usually likes a "good argument," which he also likes to win. In addition, he admitted to occasional use of amphetamines during busy times in his medical practice, and he had self-medicated on codeine after his automobile accident for about three months. He had become concerned about the codeine and had managed to taper off his use of it. One younger brother had had a recurrent alcohol problem and died from liver complications about five years ago. His father was generally a very energetic individual, but the patient remembered that on several occasions his father as moody for several weeks at a time. The wife recalled that the patient had been somewhat depressed at ages 35 and 38, but it had cleared spontaneously without his seeking treatment.

Medical History

Until the injury in the auto accident 14 years ago, Dr. B. had been in generally good health, but now he has residual stiffness and arthritis in the left arm. Following his heart attack, he made a rather good recovery in three months but has continued to have occasional angina pains on exertion, which he treats with sublinguinal nitroglycerine. Four years ago, it was found that he had early glaucoma in both eyes, as well as cataracts, which have gradually grown. He cannot drive at night because of the glare, but he has not wanted to do anything yet about the cataracts. For control of the glaucoma, he was put on pilocarpine eyedrops four times daily. He complains greatly of his eyes blurring, and he does very little reading as a consequence. When he was hospitalized two years ago, it was noted that he had frequent premature ventricular contractions (PVCs) and occasional runs of rapid ventricular heartbeat, and he was put on quinidine four times daily, with considerable improvement.

Social and Family History

The patient is the second of five children. One sister is three years older; another sister is younger. Of two younger brothers, one died five years previously. His mother, to whom he had felt very close, died of a complication of childbirth when he was 9 years old. His father was a very well known and popular general practitioner who not only had a large practice but also had been involved in politics and real estate. He was a very busy and strict person whom the patient respected but found difficult to love. There was a common expectation both by the people of the city and by his family that the patient would go into practice with his father and eventually would take over his practice. Indeed, he did work with him and had a very thriving practice, but his father died suddenly of a heart attack when the patient was 45. The father had remarried a "good woman" who treated the patient rather well, but the patient always tended to resent her and called her by her first name.

The patient's wife is four years younger than he and has a master's degree in music. They have three children: a son who is a lawyer and two married daughters, one of whom has been treated for alcoholism. None of the children live in the same town, but the patient and his wife feel that the relationships are fairly good. Both consider their marriage to be basically good.

Examination

Mental Status

When first seen, the patient had been out of the hospital for about two weeks, and thus was about three weeks from ECT. He is a large, slightly obese, white male who looks about his stated age. He was pleasant and cooperative but had an air of slight confusion and perplexity, and his speech was slow. In spite of that, he was oriented to the date, time, place, and circumstance and knew that he had had ECT, although he thought he had had just four instead of nine treatments. He could give little detail about his illness, and he was not up on current events, stating that he did not watch television and has difficulty concentrating. He described his mood as slightly depressed and "73 percent of normal." His major complaint was restlessness, and he worried that his wife was probably suffering because of his illness. There was no paranoid or delusional thinking, and his insight seemed fairly good. In some formal memory testing he got eight figures forward and five in reverse.

Functional Status

During administration of the OARS Multidimensional Functional Assessment Questionnaire, the patient was generally cooperative but tried to laugh some things off in a feeble way. He made one error on the preliminary questionnaire. On the Social Resources (SR) he was rated 2, as his wife could take care of him indefinitely; but his other family and friends had tended to drift away during his recurrent depressions. Economically he was rated 1, as he had ample income from inheritance and his own investments during his practice. On the Mental Health (MH) scale he was rated 4, or moderately impaired, because of the persistence of some depression and a mild organic mental syndrome. Physically he was rated 4, because of the existence of several problems that needed ongoing medical treatment and that interfered with his functioning. The rating on the Activities of Daily Living (ADL) scale was 3; it was close to 4 because he was not doing some things he could do; his wife was doing them for him because of his dependent attitude.

Assessment and Discussion

About three weeks after the initial contact, the case was presented to the intake conference, at which time Dr. B. was interviewed alone and then with his wife. At that time he was somewhat defensive and showed mild hostility, probably because of being in the position of patient rather than physician. He spoke with some bitterness about the things that had happened to him and brought up analogies of unfinished work and business. The examining psychiatrist felt these analogies referred not only to having had to retire early because of illness but also to possible unresolved feelings of inadequacy in light of the standards and achievements of his father. Dr. B complained of great difficulty in remembering things, but almost casually excused some of his past behavior because of his inability to remember.

When Dr. and Mrs. B. were interviewed together, it was noted that they both were very tense and rather guarded. She tended both to speak up if he hesitated and to defend him. On direct questioning, she indicated that he was occasionally rather overenergetic and overactive, and at times moody, and that he tended to drink more on these occasions. They indicated that they had a "glass or two" of sherry in the late afternoon together. They did indicate a wish for any type of treatment that might help prevent the recurring depression. She also recalled that he had been having some memory and concentration problems for several years and that these seemed variable.

The attending geropsychiatrist commented afterward that this patient presented a complicated problem consisting of a recurring affective illness, a long-standing personality problem, and somewhat more memory deficit than one would expect to see six weeks after ECT. There is a past history of some abuse of amphetamines, codeine, and alcohol, although he had apparently managed to get these under control himself. As a physician, he is part of a group at very high risk for substance abuse; the abuse rate of the profession is about 30 times that of the general population. Common potential problems are work strain, marital difficulties, physical pain, omnipotence, and easy availability of drugs. Reflection about his history of mood swings over much of his adult life, as well as his rather poor history of response to the usual tricyclic antidepressants, yielded the feeling that he may actually have manic-depressive disease that has become more obvious and more depressive in recent years. Therefore, it was recommended that a trial of lithium therapy be undertaken. The exact nature of the organic mental syndrome could not be determined this soon after ECT, but—in light of his known arteriosclerotic vascular problem—the impairment might be the result of cerebral vascular disease. More likely, it might be from drug intoxication, since he had been on quinidine, pilocarpine, and several antidepressants and tranquilizers, any one of which might produce confusion. Another possibility, in light of his exercise. The patient's lithium level stabilized, and he had few side effects other than an intermittent fine tremor. Gradually, his ability to concentrate and remember improved considerably, and he began to read again. Psychologic testing at six months showed mild, diffuse organic mental syndrome. The frequency of the visits was decreased to once monthly.

The cataracts began to grow worse, however, and after about a year he was having trouble reading and had to give up driving, which was a great blow to him. Gradually he became more and more depressed again, and the antidepressant doxepin was added at a very low dose, along with Hydergine, which has some antidepressant effect and a very low incidence of toxicity. Slowly he began to withdraw again and to get more and more confused, with hesitancy and occasional slurring of his speech. The frequency of visits was increased. He began to show some staggering in his gait, and both of them admitted to drinking a "couple" of glasses of wine together daily. He was counseled to reduce his drinking, but he denied drinking "too much." Within two weeks his situation had obviously deteriorated further; he had become quiet and lethargic and had fallen twice. He had developed marked aphasia, and as he groped for words, he had several catastrophic-type reactions with marked flushing and brief confusion. His wife admitted that he had been drinking a fifth of a gallon of sherry daily for several weeks and that she had joined him in this. When seen, he was unsteady and disoriented to time and recent events. He was disheveled and had a shaggy beard growth. He was admitted to the hospital for evaluation and withdrawal. It was noted that he complained of depression and that his liver was slightly enlarged and tender. He was tremulous; this worsened within the first 24 hours after admission, so a Librium withdrawal was undertaken. An electroencephalogram (EEG) showed diffuse cortical slowing, and a computerized tomographic (CT) brain scan showed some cortical atrophy with ventricular enlargement that the neurologist felt was compatible either with an Alzheimer's-type dementia or, more likely, an alcohol-related degeneration. Over a four-week period he improved moderately and was discharged. The patient and his wife were confronted with the neurologic deterioration. This seemed to reach them, and they both decided to give up their long-standing pattern of daily wine consumption. He stabilized physically, but remained confused and depressed after discharge. Within four months, he actually became depressed to the point of suicidal preoccupation in spite of the antidepressants lithium, Hydergine, and doxepin; he was readmitted. It was felt that the amount of medication necessary to relieve his depression was also sufficient to confuse him further. Therefore, after some debate, he underwent another course of ECT, with good results. Within about six weeks he cleared up fairly well and was put back on the lithium.

recurrent severe depressions, is that he might be manifesting a pseudodementia.

The social worker who had seen the patient, as well as his wife, for the initial evaluation was struck by the fact that this highly trained and well-known man had become so isolated. He had tended to be a "workaholic" until his illnesses handicapped him, and he had developed little in the way of recreational activities or skills. His wife described him as "sitting like a vegetable" when he was depressed, with little desire to see either his friends or his children. Recently his wife has been his main social contact.

The psychologist indicated that baseline psychologic tests would be helpful to determine the extent and progress of the organic mental syndrome. It was too close to the ECT for such tests to be of much value, however, and they should be done in three to six months.

Therapeutic Plan

The recommendation of the intake conference was that Dr. B. should be seen by one of the geropsychiatrists every other week for individual therapy, and that the wife should be seen by the social worker every other week. They should also be seen together by both therapists to help support each of them and to better understand and treat the conflicts that had arisen between them. The wife was moderately depressed, and it was felt that psychotherapy should be the primary choice for her. Dr. B., on the other hand, should be put on lithium carbonate to see if recurrences of the depression could be stopped. This would be done on an outpatient basis, with frequent checks of the serum lithium level, since older people get lithium toxicity easily at lower levels than younger people and the levels are often somewhat erratic.

The physical therapist recommended a course of physical therapy to try to decrease the pain and stiffness in the patient's left arm, as well as a general, mild progressive exercise program.

Dr. B.'s lack of interests and hobbies and his loss of social contacts are continuing problems for the patient and his wife, and the social worker indicated that efforts would be made to involve him in more social and volunteer activities and to help him renew contacts with his old acquaintances.

Intervention and Follow-up

Both Dr. and Mrs. B. were quite faithful about attending the scheduled appointments, and they were given support for Dr. B.'s slow recovery. His mood gradually improved. He began to attend a Senior Citizens' Day program, and they both joined a health spa where they occasionally did water

Subsequently, he has had gradual improvement in intellectual function, socialization, and mood. Dr. B. and his wife have been followed for two more years, and both of them remain totally off alcohol. He had his cataracts extracted about eight months after his last hospitalization and did well with that. Subsequently, he has resumed reading, and they have become socially active again. Both were surprised when he became potent again about 12 months after stopping the alcohol.

Commentary

This case represents a complicated problem of sequential prescribed and self-prescribed polydrug abuse in an individual with major affective disorder of a circular type. People like Dr. B often self-medicate with alcohol to help their depression when they are low and to slow the mania when they are excited. His profession has a high substance abuse rate, which is probably related to work stress and the availability of drugs, as well as to personality factors. He and his wife had been used to drinking almost daily much of their lives, and it was hard for them to accept the fact that alcohol had become increasingly toxic because of his increased sensitivity with age, his brain damage, and interactions with other drugs. The brain changes indicated significant damage over many years, but it is important to note that he gradually improved to a surprising extent over a year's time after stopping the alcohol. Even the professionals sometimes forget that alcohol is a potent drug, especially in the elderly.

NOTES

1. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders 3rd ed. (DSM III)*, (Washington, D.C.: American Psychiatric Association, 1980), pp. 163-179.

2. Charles Winick, "Maturity Out of Addiction," *Bulletin on Narcotics* 14 (1962): 1-7.

3. John A. O'Donnell, *Narcotic Addicts in Kentucky* (Washington, D.C.: Public Health Service, 1969), Pub. no. 1881.

4. William C. Capel and G.T. Stewart, "The Management of Drug Abuse in Aging Populations: New Orleans Findings," *Journal of Drug Issues* 1 (1971): 114-121.

5. E.F. Pascarelli, "Drug Abuse and the Elderly," *Substance Abuse. Clinical Problems and Perspectives*, eds. J.H. Lowinson and P. Ruiz (Baltimore: Williams & Wilkins, 1981), pp. 752-757.

6. A. Helps, "Friends in Counsel," in *The Home Book of Quotations*, 10th ed., ed. B. Stevenson (New York: Dodd, Mead, 1967).

7. G.L. Maddox, "Drugs, Physicians, and Patients," in *Drugs and the Elderly*, eds. D.M. Petersen, F.J. Whittington, and B.P. Payne (Springfield, Ill.: Charles C Thomas, 1979), pp. 5-13.

8. Ibid., pp. 5-13.

9. APA, *Diagnostic and Statistical Manual*, pp. 163-179.

10. Larry G. Peppers and Ronald G. Stover, "The Elderly Abuser: A Challenge for the Future," *Journal of Drug Issues* 9 (1977): 73-83.

11. Emil F. Pascarelli, "An Update on Drug Dependence in the Elderly," *Journal of Drug Issues* 9 (1979): 47-54.

12. M.A. Schuckit, "Geriatric Alcoholism and Drug Abuse," *Gerontologist* 17 (1977): 168-174.

13. David M. Petersen, F.J. Whittington, and E.T. Beer, "Drug Use and Misuse among the Elderly," *Journal of Drug Issues* 9 (1979): 5-26.

14. C. Eisdorfer and M.M. Basen, "Drug Misuse by the Elderly," in *Handbook on Drug Abuse*, eds. R.I. Dupont, A. Goldstein, and J. O'Donnell (Washington, D.C.: National Institute on Drug Abuse, U.S. Department of Health, Education, and Welfare and Office of Drug Abuse Policy, 1979), pp. 271-276.

15. D.G. Peck, "Alcohol Abuse and the Elderly: Social Control and Conformity" *Journal of Drug Issues* 9, no. 1 (1979): 63-71

16. B.L. Mishara and R. Kastenbaum, *Alcohol and Old Age* (New York: Grune & Stratton, 1980).

17. C.P. Chien, E.J. Townsend, and A.A. Ross-Townsend, "Substance Use and Abuse among the Community Elderly: The Medical Aspect," *Addictive Diseases* 3, no. 3 (1978): 357-372.

18. P.J. Forni, "Alcohol and the Elderly," in *Drugs and the Elderly*, ed. R.C. Kayne (Ethel Percy Andrus Gerontology Center, University of Southern California, 1978), pp. 75-83.

19. M.A. Schuckit, E.R. Morrissey, and M.R. O'Leary, "Alcohol Problems in Elderly Men and Women," *Addictive Diseases* 3, no. 3 (1978): 405-416.

20. A. Simon, L.J. Epstein, and L. Reynolds, "Alcoholism in the Geriatric Mentally Ill," *Geriatrics* 23 (1968): 125-131.

21. C.M. Gaitz and P.E. Baer, "Characteristics of Elderly Patients with Alcoholism," *Archives of General Psychiatry* 24 (1971): 372-378.

22. Donna S. Woolf, "CNS Depressants: Alcohol," in *Substance Abuse: Pharmacologic, Developmental and Clinical Perspectives*, eds. G. Bennett, C. Vourakis, and D.S. Woolf (New York: John Wiley & Sons, 1983), pp. 17-38.

23. APA, *Diagnostic and Statistical Manual*, pp. 101-162.

24. M.A. Schuckit and P.A. Pastor, Jr., "The Elderly as a Unique Population: Alcoholism," *Alcoholism* 2 (1978): 31-38.

25. M.J. Eckardt, "Consequences of Alcohol and Other Drug Use in the Aged," in *The Biology of Aging*, eds. J.A. Behnke, C.E. Finch, and G.B. Moment (New York: Plenum Press, 1978), pp. 191-204.

26. Gaitz and Baer, "Characteristics of Elderly Patients," pp. 372-378.

27. Criteria Committee, National Council on Alcoholism, "Criteria for the Diagnosis of Alcoholism," *American Journal of Psychiatry* 129 (1972): 127-135.

28. S. Zimberg, "Diagnosis and Treatment of the Elderly Alcoholic," *Alcoholism* 2 (1978): 27-29.

29. James T. Hartford and T. Samorajski, "Alcoholism in the Geriatric Population," *Journal of the American Geriatrics Society* 30, no. 1 (1982): 18-24.

30. D.M. Petersen and F.J. Whittington, "Drug Use among the Elderly: A Review," *Journal of Psychedelic Drugs* 9, no. 1 (1977): 25-37.

31. M.M. Glatt, "Experiences with Elderly Alcoholics in England," *Alcoholism: Clinical and Experimental Research* 2, no. 1 (1978): 23-26.

32. Allan R. Meyers et al., "Social and Psychologic Correlates of Problem Drinking in Old Age," *Journal of the American Geriatrics Society* 30, no. 7 (1982): 452-456.

33. Roger G. Dunham, "Aging and Changing Patterns of Alcohol Use," *Journal of Psychoactive Drugs* 13, no. 2 (1981): 143-151.

34. Jack H. Mendelson and Nancy K. Mello, "Diagnostic Criteria for Alcoholism and Alcohol Abuse," in *The Diagnosis and Treatment of Alcoholism*, eds. J.H. Mendelson and N.K. Mello (New York: McGraw-Hill, 1979), pp. 1-18.

35. Ruth Maxwell, *The Booze Battle* (New York: Praeger Publishers, 1976).

36. Shelia B. Blume, "Alcoholism," in *Current Therapy*, ed. H.F. Conn (Philadelphia: W.B. Saunders, 1982), pp. 921-925.

37. E.M. Pattison, "The Selection of Treatment Modalities for the Alcoholic Patient," in *The Diagnosis and Treatment of Alcoholism*. eds. J.H. Mendelson and N.K. Mello (New York: McGraw-Hill, 1979), pp. 125-229.

38. E.W. Busse and D.G. Blazer, "Disorders Related to Biological Functioning," in *Handbook of Geriatric Psychiatry*, eds. E.W. Busse and D.G. Blazer (New York: Van Nostrand Reinhold, 1980), pp. 390-414.

39. D.G. Mayfield, "Alcohol Problems in Aging Patients," in *Drug Issues in Geropsychiatry*, eds. W.E. Fann and G.L. Maddox (Baltimore: Williams & Wilkins, 1974), pp. 35-40.

40. Alexander Simon, "The Neuroses, Personality Disorders, Alcoholism, Drug Use and Misuse, and Crime in the Aged," in *Handbook of Mental Health and Aging*, eds. J.E. Birren and R.B. Sloane (Englewood Cliffs, N.J.: Prentice-Hall, 1980), pp. 653-670.

41. Bijan Etemad, "Alcoholism and Aging," *Current Psychiatric Therapies* 19 (1980): 111-114.

42. C.E. Becker, "Pharmacotherapy in the Treatment of Alcoholism," in *The Diagnosis and Treatment of Alcoholism*, eds. J.H. Mendelson and N.K. Mello (New York: McGraw-Hill, 1979), pp. 283-303.

43. E.M. Pattison, R. Coe, and H.O. Doerr, "Population Variation among Alcoholism Treatment Facilities," *International Journal of Addiction* 8 (1973): 199-229.

44. Zimberg, "Diagnosis and Treatment of the Elderly Alcoholic," pp. 27-29.

45. Schuckit and Pastor, "The Elderly as a Unique Population," pp. 31-38.

46. M.A. Schuckit and P.O. Miller, "Alcoholism in Elderly Men: A Survey of a General Medical Ward," *Annals of the New York Academy of Sciences* 273 (1976): 558-571.

47. Gaitz and Baer, "Characteristics of Elderly Patients," pp. 372-378.

48. M.J. Blusewicz et al. "Neuropsychological Correlates of Chronic Alcoholism and Aging," *Journal of Nervous and Mental Disease* 165, no. 5 (1977): 348-355.

49. Schuckit and Pastor, "The Elderly as a Unique Population," pp. 31-38.

50. D.S. Woolf, "CNS Depressants: Other Sedatives-Hypnotics," in *Substance Abuse: Pharmacologic, Developmental, and Clinical Perspectives*, eds. G. Bennett, C. Vourakis, and D.S. Woolf (New York: John Wiley & Sons, 1983), pp. 39-51.

51. Peppers and Stover, "The Elderly Abuser," pp. 73-83.

52. S. Cohen, *The Substance Abuse Problems* (New York: Haworth Press, 1981), pp. 329-335.

53. W.C. Capel et al., "The Aging Narcotic Addict: An Increasing Problem for the Next Decades," *Journal of Gerontology* 27 (1972): 102-106.

54. W.C. Capel and L.G. Peppers, "The Aging Addict: A Longitudinal Study of Known Abusers," *Addictive Diseases* 3, no. 3 (1978): 389-403.

55. P.J. Deely et al. "The Special Problems and Treatment of a Group of Elderly Chinese Opiate Addicts in New York City," *British Journal of Addiction* 74 (1979): 403-409.

56. E.F. Pascarelli and W. Fischer, "Drug Dependence in the Elderly," *International Journal on Aging and Human Development* 5 (1974): 347-357.

57. Strategy Council on Drug Abuse. *Federal Strategy for Drug Abuse and Drug Traffic Prevention* (Washington, D.C.: Strategy Council on Drug Abuse, 1979).

58. E.F. Pascarelli, "Drug Abuse and the Elderly," in *Substance Abuse. Clinical Problems and Perspectives*, eds. J.H. Lowinson and P. Ruiz (Baltimore: Williams & Wilkins, 1981), pp. 752-757.

59. Chien, Townsend, and Ross-Townsend, "Substance Use and Abuse among the Community Elderly," pp. 357-372.

60. D. Guttmann, "Patterns of Legal Drug Use by Older Americans," *Addictive Diseases* 3, no. 3 (1978): 337-356.

61. J.R. Solomon and A.S. Weiner, "Drug Misuse in the Elderly," in *Pharmacologic Aspects of Aging*, eds. L.A. Pagliaro and A.M. Pagliaro (St. Louis: C.V. Mosby, 1983), pp. 34-44.

62. Chien, Townsend, and Ross-Townsend, "Substance Use and Abuse among the Community Elderly," pp. 357-372.

63. Guttmann, "Patterns of Legal Drug Use by Older Americans," pp. 337-356.

64. A.D. Whanger and P. Lewis, "Survey of Institutionalized Elderly," in *Multidimensional Functional Assessment. The OARS Methodology*, ed. E. Pfeiffer (Durham, N.C.: Center for the Study of Aging and Human Development, 1975), pp. 71-77.

65. J. Williamson and J.M. Chopin, "Adverse Reactions to Prescribed Drugs in the Elderly: A Multicenter Investigation," *Age and Aging* 9 (1980): 73.

66. N. Hurwitz, "Predisposing Factors in Adverse Reactions to Drugs," *British Medical Journal* 1 (1969): 536-538.

67. R.C. Eberhardt and L.A. Robinson, "Clinical Pharmacy Involvement in a Geriatric Health Clinic at a High-rise Apartment Center," *Journal of the American Geriatrics Society* 27 (1979): 514.

68. A.J.D. Friesen, "Adverse Drug Reactions in the Geriatric Client," in *Pharmacologic Aspects of Aging*, eds. L.A. Pagliaro and A.M. Pagliaro (St. Louis: C.V. Mosby, 1983), pp. 257-293.

69. J.I. Walker and H.K.H. Brodie, "Neuropharmacology of Aging," in *Handbook of Geriatric Psychiatry*, eds. E.W. Busse and D.G. Blazer (New York: Van Nostrand Reinhold, 1980), pp. 102-124.

70. A.D. Whanger, "Nutrition, Diet, and Exercise," in *Handbook of Geriatric Psychiatry*, eds. E.W. Busse and D.G. Blazer (New York: Van Nostrand Reinhold, 1980), pp. 473-497.

71. D.M. Petersen and C.W. Thomas, "Acute Drug Reactions among the Elderly," *Journal of Gerontology* 30, no. 5 (1975): 552-556.

72. Pascarelli, "Drug Abuse and the Elderly," pp. 752-757.

73. W.D. Poe and D.A. Holloway, *Drugs and the Aged* (New York: McGraw-Hill, 1980), p. 108.

74. Pascarelli, "Drug Abuse and the Elderly," pp. 752-757.

75. Solomon and Weiner, "Drug Misuse in the Elderly," pp. 34-44.

76. F.N. Brand, R.T. Smith, and P.A. Brand, "Effect of Economic Barriers to Medical Care on Patient's Noncompliance," *Public Health Report* 92 (1977): 72-78.

77. D. Schwartz et al. "Medication Errors Made by Elderly Chronically Ill Patients," *American Journal of Public Health* 52 (1962): 2018-2029.

78. E. Memminki and J. Heikkila, "Elderly People's Compliance with Prescriptions, and Quality of Medication," *Journal of Social Medicine* 3 (1975): 87-92.

79. J. Gollub, "Psychoactive Drug Misuse among the Elderly: A Review of Prevention and Treatment Programs," in *Drugs and the Elderly*, ed. R.C. Kayne (Ethel Percy Andrus Gerontology Center, University of Southern California, 1978), pp. 84-102.

80. James K. Cooper, David W. Love, and Paul R. Raffoul, "Intentional Prescription Nonadherence (Noncompliance) by the Elderly," *Journal of the American Geriatrics Society* 30, no. 5 (1982): 329-333.

81. D.F. Moore, "Over-the-Counter Drugs," in *Substance Abuse: Pharmacologic, Developmental, and Clinical Perspectives*, eds. G. Bennett, C. Vourakis, and D.W. Woolf (New York: John Wiley and Sons, 1983), pp. 102-109.

82. Gollub, "Psychoactive Drug Misuse among the Elderly," pp. 84-102.

83. D.B. Larson, A.D. Whanger, and E.W. Busse, "Geriatrics," in *The Therapists Handbook, 2nd ed.*, ed. B.B. Wolman (New York: Van Nostrand Reinhold, 1983), pp. 343-388.

84. L.A. Pagliaro and A.M. Pagliaro, *Pharmacologic Aspects of Aging* (St. Louis: C.V. Mosby Company, 1983).

85. T.F. Blaschke, "Potential Drug Interactions in Aging Patients," in *Age and the Pharmacology of Psychoactive Drugs*, eds. A. Raskin, D.S. Robinson, and J. Levine (New York: Elsevier, 1981), pp. 93-103.

86. R.F. Prien, C.J. Klett, and E.M. Caffey, "Polypharmacy in the Psychiatric Treatment of Elderly Hospitalized Patients: A Survey of 12 Veterans Administration Hospitals," *Diseases of the Nervous System* 37 (1976): 333-336.

87. R. Prentice, "Patterns of Psychoactive Drug Use among the Elderly," in *The Aging Process and Psychoactive Drug Use*, National Institute on Drug Abuse, Services Research Monograph Series, pub. no. 79-813 (Washington, D.C.: U.S. Department of Health, Education and Welfare, 1979), pp. 17-41.

88. R.T. Zawadski, E.B. Glazer, and E. Lurie, "Psychotropic Drug Use among Institutionalized and Noninstitutionalized Medical Aged in California," *Journal of Gerontology* 33, no. 6 (1978): 825-834.

89. Chien, Townsend, and Ross-Townsend, "Substance Use and Abuse among the Community Elderly," pp. 357-372.

90. K.W. Back and D.A. Sullivan, "Self-Image, Medicine, and Drug Use," *Addictive Diseases* 3, no. 3 (1978): 373-382.

91. M. Hochhauser, "Learned Helplessness and Substance Abuse in the Elderly," *Journal of Psychoactive Drugs* 13, no. 2 (1981): 127-133.

The Gerontology Alcohol Project (GAP) investigated case-finding and treatment of later-life onset alcohol abusers. Extensive assessment was conducted and a self-management treatment approach was developed. Results indicated that (1) later-life onset abusers exist in numbers sufficient to warrant treatment programs specific to their age-related needs, (2) GAP's self-management approach resulted in marked success for those completing the treatment program, and (3) early attention to variables associated with treatment completion versus dropping out is needed.

Key Words: Alcohol, Behavioral treatment, Late-life, Elderly

The Gerontology Alcohol Project: A Behavioral Treatment Program for Elderly Alcohol Abusers[1]

Larry W. Dupree, PhD,[2] Helen Broskowski, PhD,[3]
and Lawrence Schonfeld, PhD[4]

Alcohol abuse has been identified as one major response to the stresses associated with aging. Prevalence estimates vary according to setting. Zimberg et al. (1978) estimate that 10 to 15% of individuals age 55 and over residing in the community abuse alcohol. Higher percentages of alcohol abuse have been reported among elderly patients admitted for medical care, surgery, or mental health treatment (Maletta, 1982; Simon et al., 1968; Zimberg et al., 1978).

Two major categories of elderly alcohol abusers have been hypothesized. The "aging alcoholic" is described as a person manifesting significant alcohol-related problems throughout most of his/her life. On the other hand, the "geriatric problem drinker" purportedly represents two distinct patterns of alcohol use. One is the person who has experienced intermittent problems with alcohol but does not develop regular abusive patterns until late middle or older age. The second is the older individual who presents no history of alcohol-related problems but develops an abusive use of alcohol in response to the stresses of aging (the later-life onset, reactive alcohol abuser). Virtually no research is available regarding later-life onset alcohol abusers. However, the later-life onset abuser's reasons for drinking are hypothesized to be more in response to fairly recent and age-related events rather than a reflection of long-term, well-defined psychological problems (Schuckit, 1977; Zimberg, 1974, 1978; Zimberg et al., 1978). Zimberg (1978) suggests that the treatment approach should place emphasis on compensating for various age-related losses/stresses.

The Department of Aging Programs of the Florida Mental Health Institute received funds from NIAAA to conduct research relative to the location, description and treatment of later-life onset alcohol abusers. The research was implemented through the Gerontology Alcohol Project (GAP), a pilot day treatment program (Dupree, 1982a; Dupree et al., 1982). Later-life onset alcohol abusers were defined as individuals age 55 and over whose onset of an abusive alcohol pattern occurred at age 50 or later. The Project followed a behavioral (A-B-C) paradigm relative to assessment and intervention, with an emphasis on the functional analysis of drinking behavior (i.e., the drinking behavior chain), acquisition of self-management skills, and reestablishment of viable social support networks (Marlatt & Nathan, 1978; Miller, 1976; Miller & Munoz, 1976; Miller & Mastria, 1977; Sobell & Sobell, 1978; Zimberg, 1974, 1978).

Method

The Sample

During the 24-month treatment phase of GAP, 406 referrals were made. During the final 6 months, however—a "phasing out" period as the grant ended—the frequency of referrals decreased markedly as no new admissions were permitted.

Of the total referrals, 304 individuals (75%) were over age 55, and of the group over age 55 153 (50.3%) definitely met the dual criteria established by GAP to define later-life onset alcohol abusers. The number meeting the later-life onset criteria might have been greater in that, for 30% of the cases, the referral sources could not provide the age of onset of the drinking problem nor could the Project verify the age of onset. For statistical purposes the unverified cases were arbitrarily considered as age-inappropriate or not later-life onset alcohol abusers.

---

[1] This project received invaluable conceptual and logistical/managerial support from Dr. Roger Patterson, Director, Department of Aging Programs, The Florida Mental Health Institute (University of South Florida) and Mr. David Eberly, Associate Director, FMHI/USF, Tampa, FL 33612. Additional thanks go to GAP staff members Georgia Everitt, Jim Glisson, George Gregoire, Dottie Harmon, John Hay, Mary Myles, Jill Post, and Ed Quill. Appreciation is expressed to Vicki Andrews for the preparation of the manuscript.

[2] Assistant Director, Department of Aging Programs, and Director, Community Aging Program, Florida Mental Health Institute (University of South Florida), Tampa, FL 33612.

[3] Director of Outpatient Services, Northside Community Mental Health Center, Tampa, FL 33612.

[4] Research Psychologist, Department of Aging Programs, Florida Mental Health Institute (University of South Florida), Tampa, FL 33612.

Of the *appropriate referrals* (i.e., those meeting GAP's dual age criteria), 61.4% were male and 38.6% were female. The mean age was 65.9 years. Mean age of onset of a defined drinking problem was 60.0 years. About half (70) of the age-appropriate referrals consented to a screening visit. Only 48, 26 males and 22 females, volunteered to participate in treatment and were formally admitted to GAP. Exactly half of the admitted clients (13 males, 11 females) dropped out of the program before completing all targeted components of treatment. The remaining half (also 13 males, 11 females) successfully completed treatment and "graduated." For the 24 graduates, follow-up data were available for 23 clients at 1 month, 22 clients at 3 months, and 21 clients at 6 and 12 months.

Assessment. — In addition to quantity and frequency of alcohol consumption, GAP assessed potential clients across five areas of life, the quality of which is affected by alcohol abuse (Pattison et al., 1977). These areas were physical health, mental health, family and social adjustment, financial stability, and legal status.

Admission, discharge and follow-up assessments included

(1) The GAP Drinking Profile, a modified version of Marlatt's (1976) assessment instrument. Past drinking history, current drinking pattern, previous treatment, and type and quantity of alcohol consumed were determined as baseline information. Discharge and follow-up assessments provided information about the client's behavior during and after treatment.

(2) The GAP Personal Stress Inventory, an interview-type assessment to determine the relationship, if any, of stressful events to alcohol abuse.

(3) The GAP Social Support Network Inventory to assess the size, quality and composition of clients' social networks.

(4) Personal Adjustment and Roll Skills (PARS; Ellsworth, 1979), an instrument designed to interview a collateral (usually a friend or relative) and obtain ratings of the client on particular behaviors, including "alcohol and drug use."

(5) State-Trait Anxiety Inventory (Patterson et al., 1980; Spielberger et al., 1973).

(6) The Beck Depression Inventory (Beck, 1972).

(7) Rotter's (1966) Locus of Control (I-E) scale.

(8) Life Satisfaction inventory (Neugarten et al., 1961), found to be a measure of the need for self esteem training as well as satisfaction with past, present, and future events in one's life (Patterson et al.,

Assessments administered at *admission and discharge* only included the Nurses Observation Scale for Inpatient Evaluation (NOSIE-30; Honigfeld et al., 1966), and the Community Adjustment Potential (CAP) scale (Hogarty & Ulrich, 1972) which assesses the client's ability to live independently in the community. These scales have been successfully used with outpatient elderly clients (Patterson et al., 1982).

Assessments administered *only upon admission* included the GAP Demographic/Psychosocial assessment, GAP Medical History, and the Brief Psychiatric Rating Scale (Overall & Gorham, 1962) which was used as an aid in judging the client's level of severity on 18 symptom constructs.

Treatment. — Using a behavioral and self-management philosophy, four treatment modules (groups) were designed specifically for elderly alcohol abusers. These modules were designed to teach clients the components of behavior chains (from general behavior to specific, individualized drinking behavior), methods for dealing with personal and "general" antecedents typically associated with abusive drinking and relapse, and the consequences of alcohol abuse. Group treatment was standardized in that procedural manuals, including assessments, were developed for each of the modules, and group leaders (trainers) were paraprofessionals trained in the use of the module-related techniques. Sessions were usually 45 minutes in duration. The four alcohol specific modules were:

(1) Analysis of Drinking Behavior (ABC's of Drinking; Broskowski & Dupree, 1981a). Following the administration of the GAP Drinking Profile, clients entered this group and were instructed in the identification of the antecedents, behavior, and consequences of any behavior (in the early sessions) and eventually their own drinking behavior chain (towards the final sessions). Assessments were written tests administered at the beginning and at the completion of the module as well as periodic quizzes on recall of antecedents and consequences. Module completion time averaged 12 sessions.

(2) Self-Management in High-Risk Situations (Broskowski & Dupree, 1982). Following completion of the "ABC" module, clients entered self-management training in which they were instructed in skills necessary for dealing with both personal and other high-frequency antecedents associated with abusive drinking. Content areas included drink refusal or peer pressure (7 sessions), cues (6), urges (4), relapse or slipping (3), depression (6), anger/frustration (10), and tension/anxiety (9). Assessments (pre- and post-tests) were either written tests or ratings of behavior rehearsals specific to each of the content areas.

(3) Alcohol Information and Education (Schonfeld et al., 1983). Clients entered this 9-session group at any time during their participation in the program. Clients learned about the medical, psychological, statistical, and theoretical aspects of alcohol abuse. Assessments were pre- and post-tests.

(4) General Problem-Solving Skills (Broskowski &

Dupree, 1981b). Clients were instructed in and practiced methods of problem identification, generating solutions, and decision-making. Assessments were written tests (pre-, post-). Completion of the module usually required 13 sessions.

Clients were also assessed for deficits in other areas such as Activities of Daily Living, Self-Esteem, Communications, and Memory Development, all of which were part of the larger ongoing Gerontology Program (Patterson et al., 1982). A Social Support Network Module was also designed to instruct clients in skills necessary to expand their social contacts and activities.

Following completion of the treatment program, clients were given follow-up schedules and reassessed at 1-, 3-, 6-, and 12-month periods.

Results

Description of GAP Admissions

Of the 48 clients admitted, almost half (21) were widowed and 10 were separated or divorced. Twenty-three clients had lived in their current residence more than two years and 22 lived alone. Most (35) had at least a high school education. The average age was 64, and the mean age of onset of the drinking problem was 58.

The following client descriptions correspond to the five areas denoted as quality of life indicators.

Physical health. — Relatively few medical problems existed at any time in the clients' lives. For example, for 43.3% of the cases, hypertension was the most frequently reported problem, followed by pneumonia (20.8%) and chest pains (20.8%). The most frequently reported physical symptoms were those that occurred after a period of drinking. The most frequently reported alcohol-related physical symptoms were hand tremors (reported by 56% of the clients), restlessness (52.1%), blackouts (43.8%), and severe "inner" shakes (43.8%).

In the year prior to admission, exactly half of the clients had been inpatients in a medical hospital, but only 25% reported being treated for alcohol-related problems. Few clients reported receiving treatment for psychiatric or emotional problems. Few medications other than antihypertensives were being used.

Financial problems. — None of the clients reported financial difficulties due to alcohol consumption. Fifty percent of the clients had a monthly income of $500 or more, and most had completed paying for their homes.

Legal problems. — As indicated by the GAP Personal Stress Inventory and demographic information, few clients (20.8%) had been arrested for DWI offenses and none were involved in court cases.

Social/interpersonal problems. — As indicated by the GAP Social Support Network Inventory, the clients had a relatively poor social network (although no norms for the elderly are available). The average size of client social networks, irrespective of the relationship or the frequency of contact, was 7.20 people. The average number of friends or acquaintances with whom they had contact on a daily basis was 0.88 people, and the average number of relatives, including spouse, was 1.30 people. Most reported they had at least one person with whom they could discuss their personal problems.

Mental health. — Although overlapping with the area of social problems, this category was evaluated by a variety of assessment instruments, many of which have also been validated on an elderly outpatient population by Patterson et al. (1982). As Table 1 indicates, with the exception of the PARS alcohol and drug use scale, most assessments did not demonstrate severe behavioral/psychological problems.

Drinking history. — A summary of the clients' drinking histories is presented in Table 2. Although

Table 1. 48 GAP Admissions: Mental Health Quality of Life Indicators

Assessment	Mean Score	SD	Implication
Brief Psychiatric Rating Scale			
Anxiety	3.44	1.8	Mild to moderate severity
Guilt	3.15	1.9	Mild to moderate severity
Depression	3.44	1.7	Mild to moderate severity
Beck Depression Inventory	10.80	8.0	None to mild depression
State-Trait Anxiety Inventory	29.70	8.6	Moderate anxiety level
Community Adjustment Potential	64.80	10.7	Capable of independent living
NOSIE-30			
Social competence	38.60	2.6	High competency
Social interest	30.30	3.5	High competency
Personal neatness	30.50	3.6	High competency
Manifest psychosis	0.13	0.5	Absence of pathology
Irritability	4.03	4.9	Absence of pathology
Retardation	0.03	1.1	Absence of pathology
Life Satisfaction	12.10	4.6	Adequate self-esteem
Locus of Control (I-E)	7.40	3.4	"Internality"
PARS Alcohol and Drug Use Scale	9.30	3.2	Poor adjustment

most clients were not abstainers early in life, alcohol abuse did not present itself as a problem until later in life. The average age of onset was 58. Many clients had sought professional help in the past, and more than half had been hospitalized at some time for alcohol treatment. Many had visited Alcoholics Anonymous at least once. Thirty days prior to the last drink consumed before admission to GAP served as a baseline period by which future assessment periods could be compared.

Prior to admission the clients drank almost daily and were frequently intoxicated. Thus, most were steady drinkers and few were weekend or binge drinkers. Alcohol consumption was measured in "SECs" (one standard ethanol content unit or SEC is equivalent to one ounce of 100-proof alcohol). The amount of alcohol consumed on a typical drinking day was 12.2 SECs, the equivalent of one of the following: 10 12-ounce cans of beer, 51 ounces of wine, or 15.25 ounces of 80-proof liquor.

A large percentage of the clients drank at home and most drank alone. Also, almost all clients reported a negative mood state (usually depression or loneliness) just prior to taking the first (daily) drink. Of the 36 events on the GAP Personal Stress Inventory, the most frequent event reported as leading to an abusive drinking pattern was death of spouse, followed by conflict with spouse.

Table 2. GAP Admissions: Drinking Profile Summary

Category	Data Summary	
Mean age of onset of drinking problem	58	(σ = 9.7)
Sought outside help for drinking problem	56%	
Hospitalized at any time for alcohol abuse	52%	
Attended AA at least once	40%	
In the 30 days before last drink prior to admission:		
Mean number of days drinking	23	(σ = 9.0)
Mean number of days intoxicated	15	(σ = 11.0)
Steady drinking pattern	58%	
Binge drinking pattern	17%	
Weekend drinking pattern	12%	
Mean alcohol consumption on typical drinking day	12.2 SECs	(σ = 10.0)
Median alcohol consumption	8.4 SECs	
Typical antecedents to drinking		
Being at home	67%	
Being alone	67%	
Experiencing negative mood state	75%	

Treatment Outcome

Group (Modular) performance. — The results of the various pre-, post-assessments for each of the alcohol specific modules are presented in Table 3. Dependent *t*-tests were performed on these data. A significant increase occurred in post-assessment scores for ABC's of Drinking, Self Management, and Problem Solving, as well as several components of the AIE module. Thus, as indicated, it would appear that the clients learned the material within the treatment groups. Interrater reliability (whole session method) was evaluated for modular assessments and agreement was found to range from 85 to 100%.

Alcohol consumption. — The ability of the 24 program graduates to maintain their drinking goals is presented in Table 4. All but two graduates remained in follow-up; one died after the 3-month assessment.

Table 3. Performance on GAP Module Assessments

Module	Component	Mean Test Score		*p*
		Pre	Post	
Self-Management	Drinking cues	4.2	5.6	.001
	Personal cues	3.9	4.4	.07
	Relapse training	3.9	6.4	.01
	Anxiety/tension	7.8	12.8	.001
	Urges (written test)	1.3	3.5	.001
	Urges (behavioral test)	8.4	10.0	ns
	Drink refusal	10.5	13.8	.001
	Depression	8.5	15.7	.001
	Anger/frustration	19.5	25.6	.05
ABC's of Drinking		14.4	25.8	.001
Problem-Solving	Problem situation #1	5.8	8.8	.01
	Problem situation #2	5.3	7.2	.05
	Decision-making recall	7.2	7.8	.01
AIE	Medical aspects	4.3	4.5	ns
	Film: Know the Facts	3.5	4.0	.07
	Alcoholism	2.3	2.8	.01
	ABC's	3.6	3.4	ns
	Addiction	3.2	3.4	ns
	Goal choice	3.4	3.8	.05
	AA	3.5	4.6	.001
	Film: Alcohol, Pills	2.2	2.8	ns
	Follow-up and success	3.4	4.1	.01

Table 4. Ability of GAP Graduates to Maintain Drinking Goals at Each Assessment Period

Assessment Period	Goal: Abstinence		Goal: Limited Drinking		Program Success (%)
	Success	Failure	Success	Failure	
Day of discharge	17	0	7	0	100
1-month follow-up	15	2	6	1	88
3-month follow-up	14	3	5	2[a]	79
6-month follow-up	14	3	4	2[a]	78
12-month follow-up	14	3	3	3[a]	74

Note. One client with a limited drinking goal died after the 3-month follow-up.

[a] Includes two dropouts as failures.

Seventeen clients chose a goal of abstinence, and 7 chose the goal of responsible, limited drinking of some kind. For statistical evaluation only, if clients violated their drinking goal at least once or if they dropped out of follow-up, they were not considered a success during the follow-up period in question. Even with this very conservative definition, "success" was very high for GAP clients attempting to maintain their desired drinking goal.

Alcohol consumption on an average drinking day was measured during different time periods: pre-admission (the 30-day "baseline" previously cited), the time in actual treatment, the 30-day period prior to discharge, and between subsequent follow-up appointments. Figure 1 illustrates median alcohol consumption for 21 GAP graduates with complete follow-up data. As shown, alcohol consumption was reduced in the program and follow-up. An analysis of variance (ANOVA) for repeated measures was performed on the data (SECs) for these 21 clients. The differences over time were found to be significant, $F(6, 114) = 10.70, p < .001$. Post hoc analyses (Fischer's L.S.D. test) revealed a significant difference between alcohol consumption at pre-admission and all subsequent periods of time. No other differences were found.

PARS indicated significant improvement (i.e., decrease in scores) in the collateral's ratings of the clients' behavior, $F(5, 70) = 15.28, p < .001$, for 15 clients with complete follow-up data. Post hoc L.S.D. tests revealed a significant decrease in mean ratings of alcohol abuse between admission ($\bar{X} = 8.9$, representing poor adjustment) and discharge ($\bar{X} = 4.1$, representing average adjustment). Follow-up PARS assessments did not show a significant difference from the discharge assessment, indicating maintenance of the improved status.

Community Adjustment

Collateral's ratings of alcohol and drug use (PARS) demonstrated a specific area of improvement. The Community Adjustment Potential (CAP) scale scores (ratings of clients by staff) also demonstrated significant improvement in functioning from admission ($\bar{X} = 67.5$) to discharge ($\bar{X} = 75.4$), $t(21) = 4.22$, $p < .001$.

Thirteen graduates had at least admission, discharge, 1-month and 12-month follow-up assessments on the GAP Social Support Network Inventory. (This instrument was developed and implemented after the first clients entered the program; thus, some clients were missing an "initial" assessment.) An improvement was observed in the size of the clients' social networks. Analysis of variance demonstrated an increase in the size of the total social net-

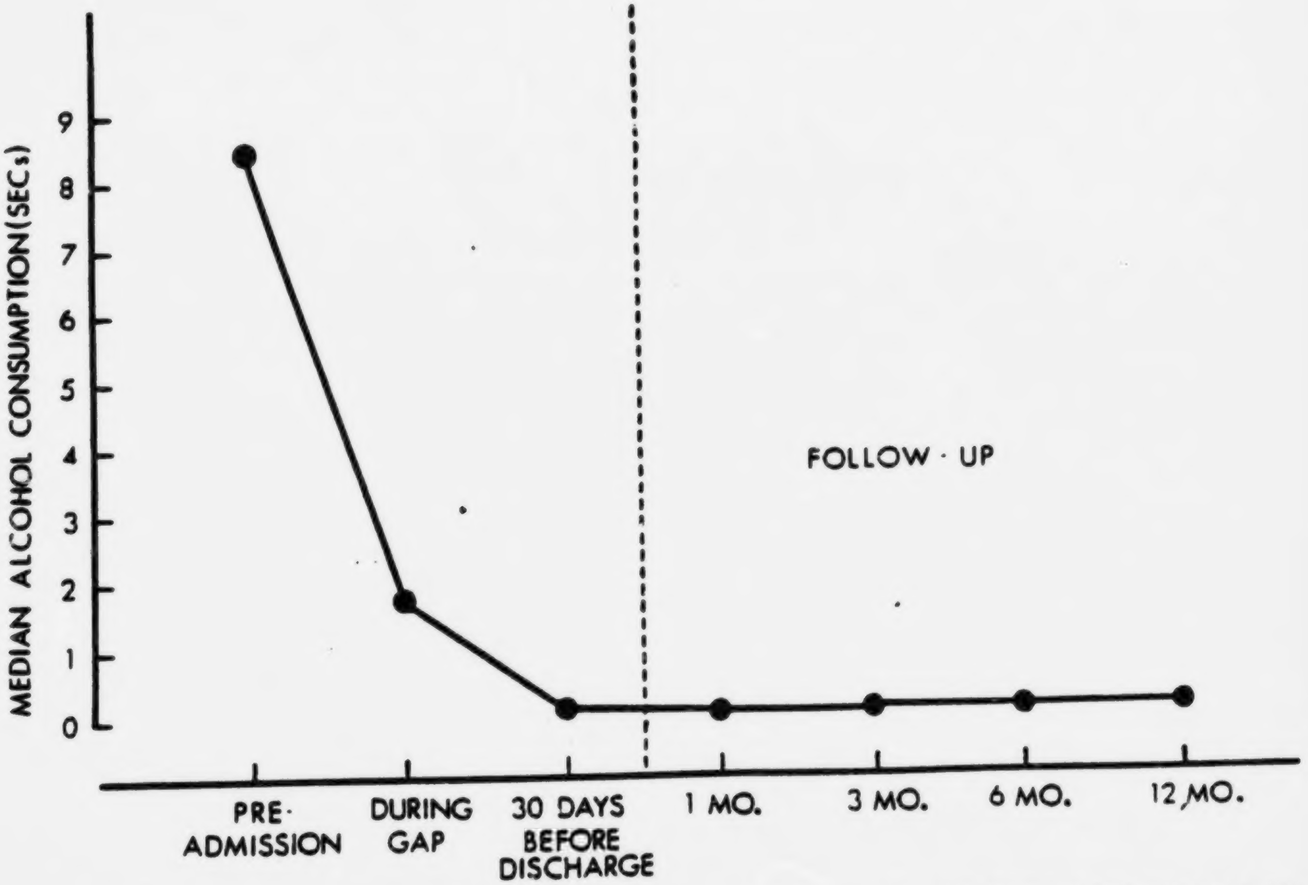


Figure 1. Median alcohol consumption for 21 GAP graduates who completed the 12-month follow-up. Data include clients with drinking goals other than abstinence. SEC = standard ethanol content unit.

work through the 12-month follow-up period, F (3, 36) = 10.63, $p < .001$, and a significant interaction of assessment period × relationship, F (3, 36) = 3.97, $p < .05$. Post hoc analyses indicated that the number of friends increased between admission ($\bar{X}$ = 4.5) and discharge ($\bar{X}$ = 8.2) and again at the one month follow-up ($\bar{X}$ = 9.3) but was maintained thereafter ($\bar{X}$ = 10.2). The number of relatives with whom clients were in contact increased between admission ($\bar{X}$ = 4.2) and discharge ($\bar{X}$ = 5.3) and was maintained at both the 1-month ($\bar{X}$ = 5.6) and 12-month follow-ups ($\bar{X}$ = 5.9). Few events which were related to alcohol abuse were recorded on updates (follow-up assessments) of the GAP Personal Stress Inventory. No client was arrested for DWI throughout follow-up, and of the few clients who "slipped" (using our very conservative definition of drinking goal success versus failure) none returned to an abusive pattern of alcohol consumption throughout follow-up.

Differences Between GAP Graduates and Dropouts

Noted differences between "graduates" and "dropouts" were observed. Subsequent discriminant analysis indicated four variables to be significantly related to the criterion of program completion (graduate-dropout groups). These were personal estimate of likelihood of obtaining one's treatment goal, perceived locus of control, reported depression, and number of SEC units consumed on a drinking day (Dupree, 1982b). The dropouts had a lower estimate of success, were more "external" on the locus of control scale, had higher depression scores, and tended to drink larger quantities of alcohol.

Differences Between Male and Female Clients

The only differences in response to assessment items between males and females occurred in response to the location in which they drank and in the frequency of seeking professional help for an emotional problem. More females drank at home than did the males, χ^2 (1) = 4.61, $p < .05$; and more females than males sought professional help for emotional problems, χ^2 (1) = 22.51, $p < .001$. No other significant differences were noted.

Discussion

The outcome of GAP can best be described in terms of the three guiding research questions: 1) Do later-life onset (reactive) alcohol abusers, as a clinical entity, exist? 2) If so, what strategies or approaches are necessary to identify and enter them into treatment? 3) What treatment modalities are appropriate for use with the elderly (and can be replicated by other professional, paraprofessional, or volunteer personnel in diverse treatment settings)?

Using GAP's criteria, it appears that later-life onset alcohol abusers can be defined both conceptually and empirically. The elderly alcohol abusers identified by GAP led fairly successful lives, providing for themselves through their own skills and resources. Alcohol abuse did not become a problem until late in life, often following cumulative "losses" and stresses associated with aging, such as death of a family member or reduction in the social network in general (e.g., by either moving away from their children and friends or their family moving away from them). Many elderly appear to drink in response to momentary feelings of depression and loneliness, as well as in response to family-related interpersonal conflict. Prior to admission, abusive drinking and intoxication appeared frequent, and many clients were steady drinkers. Thus, the later-life onset alcohol abuser appears to be using alcohol as a palliative in response to many aging-related changes and certain family-related stressful events. The alcohol abuse problem seems to be fairly discrete rather than representative of major psychological/interpersonal impairment.

The GAP developed three case-finding strategies (Dupree, 1982a) and was able to locate a substantial number of potential (criteria-appropriate) clients. Yet, only 48 clients consented to treatment. Thus, the greater difficulty does not appear to be one of defining and locating elderly alcohol abusers, but one of engaging them in appropriate and recommended treatment. Furthermore, one-half of the admitted clients dropped out of the program prior to completion, a problem common to many outpatient alcohol treatment programs. Specific to outpatient younger populations, Baekeland and Lundwall (1975) report that 52 to 75% of patients drop out by the fourth session.

The noted dropout-graduate differences warrant different kinds of initial intervention upon admission to treatment. The dropout problem is likely to continue at a high rate unless attitudinal (particularly personal efficacy) issues are attended to almost immediately upon admission (Dupree, 1982b, 1983). Personal efficacy issues would certainly seem to be critical outcome variables in any treatment program, particularly in treatment programs training (older) alcohol abusers in self-management techniques.

For those clients who completed GAP's treatment program, success as indicated by maintaining their respective goals of alcohol consumption was very high. The percentage of clients maintaining their goal at any time in follow-up is comparable to or better than other behavioral treatment program results with other populations (Miller et al., 1974; Pomerleau & Adkins, 1980; Stambul & Armor, 1977). It should be noted that the percentages of success reported for GAP clients are conservative since those clients who were not considered successful were those who had violated their drinking goal on at least *one* occasion. A "slip" however, does not necessarily imply intoxication or alcohol abuse, as some clients with a goal of abstinence consumed only one drink. In fact, no client who completed the program returned to an abusive pattern of alcohol consumption. Thus, the probability of succeeding with a "skills building," self-management approach, which also addresses the treatment needs of certain elderly clients (e.g., the "dropouts"), seems quite high. Such an approach has not only an immediate impact on the abusive behavior but also a longer-term impact in terms of reducing the likelihood of relapse by training elderly clients in skills necessary to preclude or interrupt the antecedents unique to their own drinking behavior chain (Marlatt & Gordon, 1980). All indications are that improvement does occur over time and is maintained.

We have noted that the social network of clients was relatively small prior to admission, improved steadily from admission through the 1-month follow-up appointment, and was maintained thereafter. Given that social losses (and the affect generated by such losses) typically preceded the abusive drinking behavior in GAP clients and the fact that they often drank alone at home, it seems likely that the improved social network also contributed to control over alcohol abuse.

In summary, it appears that a promising treatment program for elderly (later-life onset) alcohol abusers is available. The emphasis of the program is on teaching self-management skills specific to the antecedent bases for alcohol abuse, as well as psychosocial skills necessary to the redevelopment and maintenance of effective social support networks. The Gerontology Alcohol Project's skills training modules contributed to the marked success of those clients who completed the program. The technology of GAP continues in that it has been incorporated into the Community Aging Program with a major change: the treatment and research target population now includes all categories of elderly alcohol abusers.

References

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin, 82,* 738–783.

Beck, A. T. (1972). *Depression: Causes and treatment.* Philadelphia: University of Pennsylvania Press.

Broskowski, H., & Dupree, L. W. (1981a). *ABC's of drinking: A group training manual.* Department of Aging Programs, Florida Mental Health Institute, University of South Florida, Tampa.

Broskowski, H., & Dupree, L. W. (1981b). *General problem-solving skills: A group training manual.* Department of Aging Programs, Florida Mental Health Institute, University of South Florida, Tampa.

Broskowski, H., & Dupree, L. W. (1982). *Alcohol self-management in high-risk situations: A group training manual.* Department of Aging Programs, Florida Mental Health Institute, University of South Florida, Tampa.

Dupree, L. W. (1982a, June). *Comparison of three casefinding strategies.* Paper presented at the 3rd Annual Meeting of the Southern Gerontological Society in session with ACTION and the Florida Council on Aging, Orlando.

Dupree, L. W. (1982b). Gerontology Alcohol Project: Characteristics of treatment program graduates versus dropouts. *The Gerontologist, 22,* 258–259.

Dupree, L. W. (1983, April). *Strategies for reducing the dropout rate in outpatient alcohol programs for the elderly.* Paper presented at the 4th Annual Meeting of the Southern Gerontological Society, Atlanta.

Dupree, L. W., Broskowski, H., & Schonfeld, L. (1982, March). *The Gerontology Alcohol Project: An 18-month evaluation.* Symposium presented at the 28th meeting of the Southeastern Psychological Association, New Orleans.

Ellsworth, R. B. (1979). *Personal adjustment and role skills (PARS) scales.* Roanoke, VA: Institute for Program Evaluation.

Hogarty, G. E., & Ulrich, R. (1972). The discharge readiness inventory. *Archives of General Psychiatry, 26,* 419–426.

Honigfeld, G., Gillis, R. D., & Klett, C. J. (1966). NOSIE-30: A treatment-sensitive ward scale. *Psychological Reports, 19,* 180–182.

Maletta, G. J. (1982). Alcoholism and the aged. In E. M. Pattison & E. Kaufman (Eds.), *Encyclopedic handbook of alcoholism.* New York: Gardner Press, 779–794.

Marlatt, G. A. (1976). The drinking profile: A questionnaire for the behavioral assessment of alcoholism. In E. J. Mash & L. G. Terdal (Eds.), *Behavior therapy assessment: Diagnosis, design, and evaluation.* New York: Springer.

Marlatt, G. A., & Gordon, J. R. (1980). Determinants of relapse: Implications for the maintenance of behavior change. In P. O. Davidson & S. M. Davidson (Eds.), *Behavior medicine: Changing health lifestyles.* New York: Brenner/Mazel Publishers.

Marlatt, G. A., & Nathan, P. E. (Eds.) (1978). *Behavioral approaches to alcoholism.* New Brunswick, NJ: Center of Alcohol Studies.

Miller, P. M. (1976). *Behavioral treatment of alcoholism.* New York: Pergamon Press.

Miller, P. M., & Mastria, M. A. (1977). *Alternative to alcohol abuse: A social learning model.* Champaign, IL: Research Press.

Miller, P. M., Stanford, A. G., & Hemphill, D. P. (1974). A social learning approach to alcoholism treatment. *Social Casework, 55,* 279–284.

Miller, W. R., & Munoz, R. F. (1976). The ability to be assertive. *How to control your drinking.* Englewood Cliffs, NJ: Prentice-Hall.

Neugarten, B., Havighurst, R., & Tobin, S. (1961). The measurement of life satisfaction. *Journal of Gerontology, 16,* 134–143.

Overall, J. E., & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological Reports, 10,* 799–812.

Patterson, R., Dupree, L. W., Eberly, D. A., Jackson, G. M., O'Sullivan, M., Penner, L., & Kelly, C. D. (1982). *Overcoming deficits of aging: A behavioral approach.* New York: Plenum Publishing.

Patterson, R., O'Sullivan, M., & Spielberger, C. O. (1980). Measurement of state trait anxiety in elderly mental health clients. *Journal of Behavioral Assessment, 2,* 89–97.

Pattison, E. M., Sobell, M. B., & Sobell, L. L. (1977). *Emerging concepts of alcohol dependence.* New York: Springer.

Pomerleau, O., & Adkins, D. (1980). Evaluating behavior and traditional treatment for problem drinkers. In M. B. Sobell, L. C. Sobell, & E. Ward (Eds.), *Evaluating alcohol and drug abuse treatment effectiveness: Recent advances.* New York: Pergamon Press.

Rotter, J. B. (1966). Generalized expectancies for internal vs. external control of reinforcement. *Psychological Monographs, 80* (1, Whole No. 609).

Schonfeld, L., Dupree, L. W., Gregoire, G., & Broskowski, H. (1983). *Alcohol information and education for elderly alcohol abusers: A group training manual.* Department of Aging Programs, Florida Mental Health Institute, University of South Florida, Tampa.

Schuckit, M. A. (1977). Geriatric alcoholism and drug abuse. *The Gerontologist, 17,* 168–174.

Simon, A., Epstein, L., & Reynolds, L. (1968). Alcoholism in the geriatric mentally ill. *Geriatrics, 23,* 125–131.

Sobell, M. B., & Sobell, L. C. (1978). *Behavioral treatment of alcohol problems.* New York: Plenum.

Spielberger, C., Edwards, D., Lushene, R., Montouri, J., & Platzek, D. (1973). *STAIC: Preliminary manual for the state trait anxiety inventory for children.* Palo Alto, CA: Consulting Psychologists Press.

Stambul, H., & Armor, D. (1977). Outcomes in alcoholism treatment. Paper prepared for the *National Institute on Alcohol Abuse and Alcoholism Third Special Report to the U.S. Congress on Alcohol and Health.* Washington, DC: U.S. Government Printing Office, DHEW Publication No. ADM 78-569.

Zimberg, S. (1974). The elderly alcoholic. *The Gerontologist, 14,* 221–224.

Zimberg, S. (1978). Treatment of the elderly alcoholic in the community and in an institutional setting. *Addictive Diseases, 3,* 417–427.

Zimberg, S., Wallace, J., & Blume, S. (1978). *Practical approaches to alcoholism psychotherapy.* New York: Plenum Press.

BLANK PAGE

Prevalence and risk of medication mismanagement by the elderly

Harvey J. Landress, MSW, ACSW and Mary Ann Morck

ABSTRACT: As a result of the high rate of consumption of prescription medications and over-the-counter preparations by the elderly, there is an accompanying potential for patient misuse of such medication. A study of 354 elderly persons in Pinellas County, Florida, was conducted to determine the extent of their medication use and misuse. Additionally, an assessment was made with respect to the extent of their risk of medication misuse. The results of the study indicated that two-thirds of the population surveyed was "at risk" of medication mismanagement as measured by the quantity and frequency of use of prescribed medications. 43% were considered "at risk" with regards to potential misuse of over-the-counter drugs, and 58% were at moderate or high risk of misuse of both over-the-counter and prescription medications. A total of 83% of all respondents engaged in at least one unsafe medicating practice. Taken as a whole, a picture emerges of the elderly being at notable risk with regards to engaging in unsafe medication practices. Suggestions are provided to the physician on how to reduce the risk of medication misuse by their elderly patients.

The Authors
HARVEY J. LANDRESS, MSW, ACSW
MARY ANN MORCK
Mr. Landress is Planning Director of Operation PAR, Inc. and Ms. Morck is Community Education Director of Operation PAR, Inc.

Drug therapy, whether physician or self-prescribed, is the cornerstone of treatment for the elderly to improve their quality of life and prevent and treat physical and emotional disabilities. While the elderly as a group nationally consume 25% of all prescription medication,[1] they constitute only about 12% of the population. In some counties in Florida, however, they surpass 40% of the population. The disproportionate consumption of prescription medications and over-the-counter drugs is understandable when one considers that the elderly also suffer from a larger share of serious illnesses.[2] It would appear that the potential for patient misuse of medication accompanies a high rate of drug usage. This paper presents a brief overview of the scope of medication misuse by the elderly, and reports the results of a survey of 356 residents of Pinellas County with respect to medication use practices.

Available research suggests that concern for the elderly because of potential medication misuse is well founded.[1] Research is not always complete and at times quite spotty but a picture emerges as to the areas of misuse which can be clearly identified. Patients and self-prescribers make errors following specific directions of physicians or directions on medicine labels including dose omissions, timing, early discontinuance, use of outdated medications, and exchange of medications. Using prescription drugs with improper combinations of food or other medications or failing to recognize side effects contribute to further complications. One can speculate that failing eyesight, increasing memory defects, not uncommon with the elderly, and confusing medication patterns warranted by multiple medical disorders contribute to medication misusage.

Assessing the scope of the problem • Accurate indicators of patient noncompliance with prescription medications are not available. Hussar[4] noted a wide variation of noncompliance rates ranging from one third to one half of all patients sampled. He reported difficulty in determining demographic variables relating to compliance or noncompliance but did cite characteristics of patients more likely to be in noncompliance such as those with chronic illnesses requiring long-term therapy, who live alone, receive multiple medications requiring frequent administration, and patients with psychiatric illnesses.[5]

Stewart and Cluff[6] also conducted a comprehensive review of patient noncompliance and discovered the rate ranged from 20-80%. They further noted that noncompliance resulted in additional serious health risks in from 4% to 45% of patients.

In a study funded by the state of Florida, Doyle and Hamm[7] surveyed a random sample of elderly residents in Jacksonville. With a response rate of over 70%, nearly 72% reported they did not discuss medications given by one doctor while simultaneously being treated by another and 84% indicated usage of over-the-counter medications — a fact not shared with their physicians or pharmacists. Doyle and Hamm also found that patients tended to discontinue medications they disliked, maintained outdated medications and engaged in the practice of "sharing" prescribed medications. This particular practice was found mostly within family situations. About 40% indicated they did not continue to take medications they disliked and slightly less than half took medications until their physicians told them to stop.

Patient misuse of medication is further prompted by the "If one pill helps a little bit, then two must help me more" kind of logic. This thinking may be encouraged by "take as needed" directions. While relevant research in this area is not abundant, such misuse patterns have been widely noted by those working with the elderly.[8]

Peterson and Thomas[9] examined medical records of the emergency room of a hospital in Dade County and found indications of a high incidence of multiple drug use. Of acute drug reactions, 100% were found to involve legally prescribed medications. Hood[10] has shown that 2% to 8% of all hospital admissions are a direct result of drug-induced diseases and the elderly show a rate 1.5 times that of younger persons.

Because elderly persons have more multiple diseases than the general population, it is not uncommon for them to be seeing more than one physician who may be unaware that their patients are receiving other medications. With such occurrence, the possibility of unfavorable drug reactions increases.

This brief review describing the scope of problem was the basis for a study in Pinellas County in spring 1983 to determine use and abuse patterns among that county's elderly population.

Methodology • Two survey instruments were designed to elicit information regarding prescription drug use, over-the-counter medication, general health and related demographic factors. The first questionnaire included 35 questions and was administered to 271 participants in eight congregate dining and day care sites. The second, an abbreviated version of the first, was administered to 85 individuals at a local "Senior Citizen Showcase of Services" program. Both surveys were part of a special medication management and education program conducted by Operation PAR, Inc. of Pinellas County, a local substance abuse education, prevention and treatment agency.

All questions required a forced choice with an option to explain a notation of "other" and were presented in large bold face type on brightly colored paper to ease any reading problems. Staff was available to assist those with poor eyesight. Several participants indicated inability to read the survey but were in total control of their medication.

Profile of participants • Of 356 people surveyed, 60.1% were women, 92.4% were white, 34.4% were 60 to 69 years old, 39.3% aged 70 to 79, 26.3% 80 and older, 48.1% lived alone while only 2% resided in some form of group care. Several questions were included to determine general health. Respondents were asked to indicate how many of a listing of common ailments they tended to suffer from regularly and 16.6% identified one, 15.5% two, 13.6% three, 28.1% four or more, and 26.2% none (Table 1). In total 73.8% indicated one or more complaints.

Table 1. — Common Ailments Cited By Respondents, N = 271.

Rank	Condition	% Respondents Citing Condition
1	Arthritis	58.5%
2	Colds	49.5%
3	Leg Cramps	48.5%
4	High Blood Pressure	45.5%
5	Gas/Indigestion	30.5%
6	Coughs	25.5%
7	Headaches	24.0%
8	Stomach Problems	19.5%
9	Flu	19.0%
10	Chest Pain	15.5%

Respondents were asked to categorize their health and 85.5% indicated either "fair" or "good," 9.3% "excellent," 5.2% "poor," and 66.8% were under regular care by a physician. When asked how frequently they visited a doctor, 21% indicated once a month, 33% twice a year, and 20.6% once a year. The average respondent was sick 3.4 days in the past two months and 68.4% reported current use of prescribed medication.

The typical survey respondent was female, aged 70-79, lived alone, under regular doctor's care, suffered from three somatic complaints (probably arthritis), considered her health "good," and took prescribed medication.

Prescription drug use patterns • Nine survey questions directly concerned prescription drug use. In addition to eliciting information about the amount and frequency of prescription drug use, the survey questions were designed to identify unsafe medicating practices.

Both the number of different prescribed medications taken and the frequency of such use can be considered possible "risk" factors, especially since drug therapy may involve multiple prescriptions and complicated medication schedules.

Of those persons taking prescribed drugs, 62% were taking one to two, 26% three to four, and 12% five or more. A total of 38% of those who indicated prescription drug use were considered to be "at risk," this being defined as concurrent use of three or more drugs. The more frequently a patient has to be medicated, the higher the risk of error. Recognizing that forgetfulness and confusion are sometimes associated with advancing age, complicated medicating schedules create an additional "risk" factor. Table 2 indicates the number of times survey respondents were medicated daily, nearly two thirds (62.3%) two or more times and more than one third (36.5%) three or more times.

When the data are analyzed, taking into account both the number and frequency of prescribed medications taken, a clearer picture of "risk" emerges. For purposes of this study, "low risk" was considered taking one to two medications once per day, "moderate risk" one to two medications two or more times daily or three or more prescriptions once per day, and "high risk" three or more medications two or more times daily.

Table 2. — Number of Times Patients Medicated Daily, N = 260.

One time	37.7%
Two times	25.8%
Three times	21.9%
Four times	12.3%
Five or more times	2.3%

Table 3. — Patients "At-Risk" of Medication Mismanagement as Measured by Quantity and Frequency of Prescribed Medications, N = 248.

Low risk	32.7%
Moderate risk	36.2%
High risk	31.0%

Table 3 shows the risk factor for patients as measured by quantity and frequency of taking prescribed medications. Of 248 respondents 89% took one to four medications one to four times daily. One third (32.7%) were considered "low risk" while 67.2% were at some level of risk with regards to the quantity of medication taken combined with complicated medicating schedules. The distribution of low-moderate-high risk practices is fairly equal with each representing approximately one third of those surveyed.

One major unsafe medicating practice concerns the failure of patients to adhere to prescribed medicating schedule. Of 286 respondents 41.6% indicated they missed their schedule at least once. When asked why, two thirds (67.1%) said they forgot and one third (32.9%) purposely did not take the drug. These reasons are detailed in Table 4.

When asked what they would do in an incident of missed medication, 74.8% indicated they would wait until the next appropriate time and 13.2% stated they would take another dose as soon as they realized the previous dose was missed.

Of 287 respondents 21.3% said they had quit taking medicine when feeling better. When asked what they did with left-over medication, one third (34%) said they saved it for later, 2.3% shared it with someone else and two thirds (63.7%) threw it out. Maintaining unused medications and sharing with friends are two unsafe behaviors practiced by 36.3% of all respondents.

Table 4. — Reasons Cited for Missing Medications, N = 176.

Forgot	67.1%
Felt better	15.3%
Did not help	6.8%
Felt worse	4.5%
"Others"	6.3%

When asked how many old prescriptions they had on hand, 11.2% indicated they had none, 69.4% from one to three, 13.8% from four to six, and 5.8% seven or more. In total 88.8% had one or more unused prescription medications at home and 19.4% four or more. Such persons are considered to be at higher risk of medication misuse.

When assessing patients' knowledge or understanding of potential side effects, 65.9% indicated they were aware of these potentials while one third (34.1%) indicated no knowledge or understanding. This represents another risk factor for the elderly.

Survey respondents were also asked to identify what they would do if they felt "sick" and did not go to the doctor. The results are noted in Table 5. Only 20.1% indicated they would secure advice from either a physician or pharmacist. These are the only responses that involve a medical professional. Of the respondents 79.9% engage to some degree in self-diagnostic and self-prescribing behaviors. When asked if they ever telephoned the doctor for a prescription, 42.9% of 322 respondents answered affirmatively.

Table 5. — Patient Response to Illness Without Seeing Physician, N = 204.

Do nothing	33.3%
Buy something from the store	19.1%
Use home remedy	15.2%
Use old prescription	11.8%
Talk to pharmacist	9.3%
Talk to doctor	10.8%
Borrowed from friends	0.5%

It is interesting that only 0.5% used medications borrowed from friends; however, it was previously noted that 2.3% shared medications. This indicates that patients may share with others but very few use such borrowed medications.

Thus, it can be seen that the elderly are at risk with respect to the amount and frequency of medication utilized. Additionally, a substantial portion engage in one or more unsafe practices including failure to adhere to medicating regimen, keeping unused medications, not knowing or understanding potential side effects and engaging in self-diagnostic/self-prescribing behaviors. The latter is, without doubt, encouraged by the massive advertising of over-the-counter preparations. People are encouraged to review their symptoms, assuming the condition does not warrant a physician's visit, and become their own diagnostician and pharmacist.

Over-the-counter medications ● Of survey respondents 49.1% indicated use of over-the-counter (OTC) drug preparations and 44.5% of 317 respondents indicated they used OTC medications while concurrently using prescription medication.

Because OTC drugs may have serious side effects if used inappropriately for prolonged periods of time or in conjunction with prescribed medications, respondents were asked if they consulted with their physician when taking OTC and prescription drugs. Table 6 shows that nearly three fourths either never (41.3%) or sometimes (29.7%) consulted their physician.

Respondents were surveyed to determine how they received information about OTC drugs. Responses are noted in Table 7. More than one third (35.4%) relied on their doctor and one fifth (20.5%) on their pharmacist. Thus, more than half of those surveyed (55.9%) depended upon professional advice. The number of respondents who relied on advertising (18.3%) as well as advice from friends and relatives (17.8%) was almost equal. Only 9% gained information from product labels.

When asked if they were able to read over-the-counter product labels or instructions, 73.8% responded "always," 18.1% "sometimes," and 8.1% "never." Thus, more than one fourth (26.2%) of 309 respondents indicated difficulty reading product labels. This inability is a notable risk factor.

Respondents were surveyed regarding their personal use of OTC drugs. They were asked to indicate how many of what kinds of medications they had on

Table 6. — Consulting a Physician When Using Over-the-Counter and Prescribed Medications, N = 259.

Always consulted	29.0%
Sometimes consulted	29.7%
Never consulted	41.3%

Table 7. — Over-the-Counter Medication Information Sources, N = 268.

Doctors	35.4%
Pharmacists	20.5%
Advertising	18.3%
Friends/relatives	17.8%
Product labels	9.0%

hand. Ten common OTC drug types were listed along with the ability to note "others." Table 8 indicates the most frequently cited OTC medications. The most popular was aspirin/pain reliever (25.9%), second laxatives/diuretics (16.3%) followed closely by vitamins (15.6%). These three accounted for nearly 60% of the most frequently kept OTC medications. When antacids (9.5%), cough remedies (8.8%) and cold medicines (7.3%) are also included, they cumulatively account for 83.4% of the most frequently used OTC preparations.

When it is considered that occasional or prolonged use of these drugs can lead to adverse reactions not only when used by themselves but especially in conjunction with prescribed medications, there is notable increased risk for the elderly taking such drugs. This is especially so when OTC drugs cause symptoms simulating other disorders. A danger arises when these symptoms are treated by the patient or physician and not recognized as being drug related.

Respondents were asked the number of OTC medicines they had on hand at home (Table 9). Only 18.9% indicated none, 39.5% one to three, and 41.6% four or more. Additionally, of the 41.6% of the elderly who had four or more drugs on hand, 19.4% indicated they also had four or more different prescription medications. The risk of experiencing problems with OTC drugs taken in combination with prescription drugs increases as the frequency of each variable increases.

It is interesting to note that while 18.9% said they had no OTC drugs on hand at home, 51.9% said they did not use OTC drugs. This difference can be explained in only two ways: either the drugs were on hand and never used or, more likely, they used OTC drugs but did not consider them "over-the-counter" medications.

Risk levels were established based on the assumption that the risk of incompatible combinations of prescribed and OTC drugs increases in relation to the quantity available. The following risk levels were established:

Risk Level	Definition
No risk	No OTC drugs and no prescriptions
Low risk	0-3 OTC drugs and 1-2 prescriptions 1-3 OTC drugs and no prescriptions
Moderate risk	0-6 OTC drugs and 3-6 prescriptions 4-6 OTC drugs and 0-2 prescriptions
High risk	7 or more OTC drugs or 7 or more prescriptions

Analysis of the data is indicated in Table 10. Onl 4.2% of respondents had no risk and 37.6% low risk therefore, 41.8% had low or no risk with respect t OTC and prescription drug use. However, 58.2% indicated risk levels from moderate (44.6%) to hig (13.6%). Thus, it can be concluded that a notabl majority of the elderly are at risk of medication mismanagement because of the number of prescribe medications they take as well as the number of ove the-counter preparations they maintain on hand.

Several factors explored in the survey can b identified as unsafe medicating practices: discontinuance of medication if feeling better, saving old leftover medication for future use, when sick, enga ing in self-diagnostic/medicating practices such buying something from the drug store, using an o prescription, using a home remedy, or borrowi medicine from a friend or relative, using over-th counter and prescribed medications concurrent with no consultation with a physician, and missi taking prescription medication.

Table 9. — Quantity of Over-the-Counter Drugs on Hand, N = 354.

None	18.9%
1	11.6%
2-3	27.9%
4-7	36.2%
8-12	5.4%

Table 8. — Most Frequently Kept at Home Over-the-Counter Medications, N = 354.

Aspirin/bufferin	25.9%
Laxatives/diuretics	16.3%
Vitamins	15.6%
Antacids	9.6%
Cough medicines	8.8%
Cold medicines	7.3%
Nasal Spray	4.3%
Iron pills	3.5%
Sleeping pills	3.2%
Mineral oil	1.9%
Others	3.7%

Table 10. — Risk Levels of OTC and Prescription Drug Use, N = 354.

No risk	4.2%
Low risk	37.6%
Moderate risk	44.6%
High risk	13.6%

Information was available on the prevalence of each unsafe medicating practice. Table 11 shows their distribution. The most frequently cited was concurrently using prescription medications and OTC drugs without medical consultation (70%). Self-diagnosis/self-medication (57.5%) ranked second while telephoning for a prescription (42.9%) ranked third. It should be noted, however, that risk increases as more than one unsafe medicating behavior is practiced.

A total of 83.1% of all respondents indicated at least one unsafe medicating practice. Table 12 shows the rate and risk of involvement. Of those surveyed 43.7% were considered low or no risk. On the other hand 56.3% were moderately at risk (49.3%) or at high risk (7%).

Risk is further increased when it is considered that 26.2% had difficulty reading labels. Further, 23.4% took medications which were similar in color or shape and 23.9% "sometimes" and 9.6% "always" had difficulty distinguishing one medicine from another.

Taken as a whole, a picture emerges of the elderly being at notable risk with regard to engaging in unsafe medication practices. For the physician, the level of risk for elderly patients could be reduced or ameliorated by the following actions:

Specifically asking patients whether they are taking other prescribed medications or OTC preparations.

Specifically instructing patients on the use of the medications.

Asking patients to contact the physician if new symptoms develop while they are taking prescribed medication.

Discussing potential side effects of medications so patients will not self-medicate such symptoms.

Inquiring whether there is difficulty taking medications such as confusion in color, size or shape.

Discussing their OTC drug self-medicating behaviors.

While no single action can decrease medication mismanagement by the elderly, the physician does have an important role to play in creating a climate whereby potential, unsafe medicating practices can be identified and discussed. The results of this study as well as other research clearly demonstrates that a majority of the elderly engage in unsafe medicating practices. By asking a few additional questions and clearly discussing proper use of prescribed and over-the-counter medications, risk of mismanagement can be reduced.

Table 11. — Respondents Engaging in Unsafe Medicating Practices, N = 354.

Using OTC and prescription drugs without medical consultation	70.0%
Self-diagnosis/self-medication	57.5%
Phoned doctors for prescription	42.9%
Missed prescription	41.6%
Failed to discard old medicines	36.3%
Discontinued prescription if feeling better	21.3%

Table 12. — Rate and Risk of Involvement in Unsafe Medication Practices, N = 354.

No unsafe practices	16.9% (no risk)
1 unsafe practice	26.8% (low risk)
2-4 unsafe practices	49.3% (moderate risk)
5-6 unsafe practices	7.0% (high risk)

References

1. Pascarelli, E.: Drug Dependence: An Age-Old Problem Compounded by Old Age. Geriatrics 29:209-225, 1974.
2. Manard, B.B.: Old Age Institutions. Lexington, Mass., Lexington Books, 1975.
3. Butler, R.N.: Introductory Statement, Proceedings, Medication Mismanagement and Education of Elderly, Nutley, N.J., Excerpta Medica, 1978.
4. Hussar, D.A.: Patient Noncompliance, J.A. Pharmacological As. 15:183-190, 1975.
5. Prentice, R.: Patterns of Psychoactive Drug Use Among the Elderly, in The Aging Process and Psychoactive Drug Use, Washington, D.C., National Institute of Drug Abuse, 1979.
6. Stewart, R.B. and Cluff, L.E.: Review of Medicating Error and Compliance in Ambulatory Patients, Clin. Pharmacol. Therap. 13:463-468, 1972.
7. Doyle, J.P. and Hamm, B.M.: Medication Use and Misuse Study Among Older Persons. Jacksonville, Fl., The Cathedral Foundation of Jacksonville, Inc., 1976.
8. Peterson, D.M. and Whittington, F.J.: Drug Use Among the Elderly: A Review, J. Psychedelic Drugs, 9:25-37, 1977.
9. Peterson, D.M. and Thomas, C.W.: Acute Drug Reactions Among the Elderly. J. Gerontol. 30:552-556, 1975.
10. Hood, J.C.: Improving Use of Medication by Elderly Patients — A Learner's Manual for Pharmacists and Pharmacy Students, St. Petersburg, Operation PAR, Inc., 1979.
11. Doyle, J.P. and Hamm, B.M.: Op. Cit.

- Mr. Landress, Operation PAR, Inc., 6613 49th Street North, Pinellas Park 33565.

BEST COPY AVAILABLE

THE TAMPA TRIBUNE, Tuesday, May 27, 1986

National Briefs

Expert: Drugs may harm elderly

PHILADELPHIA — As many as one in seven hospital admissions among the elderly may be due to adverse reactions to drugs taken to battle problems that come with growing old, a pharmacology expert warned.

Drug interaction and overmedication may be the cause of many episodes of syndromes associated with growing old, including senility, forgetfulness and disorientation, said Dr. George Simpson, director of clinical psychopharmacology at a psychiatric institute run by the Medical College of Pennsylvania.

"The more pills that you get, the more possibilities there are for drug interaction," he said. "Somewhere along the line, some of these drugs can have negative effects."

Little is actually known about how elderly people react to drugs, he said, because medicines are usually tested on younger subjects — but it is estimated adverse drug reactions are responsible for one in seven hospital admissions among the elderly.

BLANK PAGE

TABLE I.—Classification of psychoactive drugs

Type of Class	Examples: Generic Names	Examples: Trade Names
Prescription Drugs		
Major tranquilizers		
Phenothiazine derivatives	Chlorpromazine, thioridazine	Thorazine, Mellaril
Butyrophenones	Haloperidol	Haldol
Thioxanthenes	Thiothixene, chlorprothixene	Navane, Taractan
Minor tranquilizers		
Substituted diols	Meprobamate, tybamate	Equanil, Miltown, Tybatran
Benzodiazepines	Chlordiazepoxide, diazepam, oxazepam	Librium, Valium, Serax
Miscellaneous	Hydroxyzine, buclizine	Atarax, Softran
Antidepressants		
Tricyclics	Imipramine, amitriptyline	Tofranil, Elavil
Monoamine oxidase inhibitors	Isocarboxazid, phenelzine	Marplan, Nardil
Other	Methylphenidate, combination of amitriptyline and perphenazine	Ritalin, Triavil, Etrafon
Stimulants		
Amphetamines	Detroamphetamine (and combinations), methamphetamine	Dexedrine, Dexamyl, Desoxyn
Others	Deanol, pentylenetetrazol (and combinations)	Deaner, Metrazol
Sedatives		
Barbiturates (long-acting and intermediate-acting)	Phenobarbital, butabarbital	Eskabarb, Butisol
Others	Bromisovalum	Bromural
Hypnotics		
Barbiturates (short-acting)	Secobarbital, pentobarbital	Seconal, Nembutal
Others	Glutethimide, ethchlorvynol	Doriden, Placidyl
Over the Counter		
Stimulants	Caffeine	No-Doz, Vivarin, No-Nod
Tranquilizers	Scopolamine and/or methapyrilene	Cope, Compoz
Sleeping pills	Scopolamine and/or methapyrilene	Sleep-Eze, Mr. Sleep, Sominex, Nytol

Abbreviated list of drugs affecting taste and smell
(Adapted from Schiffman, 1983)

Classification	Drug
Anesthetics, local	Benzocaine and others; cocaine hydrochloride
Anticholesteremic	Clofibrate
Anticoagulants	Phenindione
Antihistamines	Chlorpheniramine maleate
Antimicrobial agents	Amphotericin B; ampicillin; streptomycin; tetracycline
Antiproliferative, including immunosuppressive agents	Doxorubicin and methotrexate; azathioprine; carmustine
Antirheumatic, analgesic-antipyretic, anti-inflammatory agents	Allopurinol; gold; D-penicillamine; phenylbutazone
Antithyroid agents	Carbimazole
Diuretics and antihypertensive agents	Captopril; diazoxide; ethacrynic acid
Muscle relaxants and drugs for treatment of Parkinson's disease	Baclofen; chlormezanone; levodopa
Opiates	Codeine; hydromorphone hydrochloride; morphine
Psychopharmacologic, including antiepileptic drugs	Carbamazepine; lithium carbonate; phenytoin; psilocybin
Vasodilators	Oxyfedrine; bamifylline hydrochloride

BLANK PAGE

ug	Percentage of Alcohol
ctoi Expectorant Syrup	12.5
ertonic	0.45
urate Elixir	20.0
nbenyl Expectorant	5.0
ahist	0.5
omatic Elixir	22.0
aspaz – Pb Liquid	15.0
bron Elixir	15.0
erax Syrup	0.5
ctrim Suspension	0.3
. Belladonna	67.0
nadryl Elixir	14.0
ntyl – Pb Syrup	19.0
nylin Expectorant	5.0
ondecon Elixir	20.0
onkelixir	19.0
tibel Elixir	7.0
lcidrine Syrup	6.0
s Evac	18.0
romatic Cascara Sagrada	18.0
rbrital Elixir	18.0
rose & Cerose DM Expectorant	2.5
heracol & Cheracol D.	3.0
holedyl Elixir	20.0
hlor – Trimeton Syrup	7.0
ologel Liquid	6.0
itra Forte Syrup	2.0
oldene Cough Syrup	16.0
onar Expectorant	5.0
oryban D	7.5
osanyl DM & Cosanyl Syrup	6.0
opavin Cmpd Elixir	7.0
arvon–N Suspension	1.0
ecadron Elixir	5.0
exedrine Elixir	10.0
emazin Syrup	7.5
ilaudid Cough Syrup	5.0
lixir Dimetane	3.0
imetane Expectorant	3.5
imetane Expectorant – D.C.	3.5
oxinate Liquid	5.0
imetapp Elixir	2.3
imacol Liquid	4.75
onnatal Elixir	23.0
onnagel Suspension	3.8
onnagel PG Suspension	5.0
ramamine Liquid	5.0
eosol Elixir	5.0
er–In–Sol Syrup	5.0
heolixir (Elixir Theophylline)	20.0
lixophylline	20.0

Drug	Percentage of Alcohol
Elixophylline – KI	10.0
Ephedrine Sulfate Syrup U.S.P.	3.0
Ephedrine Sulfate Syrup – Note U.S.P.	12.0
Fer–In–Sol Drops	0.2
Geriplex – FS	18.0
Gevrabon Liquid	18.0
Kaon Elixir	5.0
Kaochlor	3.8
Iberet Liquid	1.0
Isuprel Comp. Elixir	19.0
Syrup Ipecac	2.0
Hydryllin Comp.	5.0
Hycotuss Expectorant & Syrup	10.0
Kay–Ciel Elixir	4.0
Lanoxin Elixir Pediatric	10.0
Liquid Lomotil	15.0
Luffyllin – GG Elixir	17.0
Marax Syrup	5.0
Mediatric Liquid	15.0
Modane Liquid	5.0
Mellaril Concentrate	3.0
Mesopin Elixir	12.5
Minocin Syrup	5.0
Nembutal Elixir	18.0
Novahistine DH	5.0
Nicol Elixir	10.0
Novahistine Expectorant	5.0
Novahistine Elixir	5.0
Novahistine DMX	10.0
Nico–Metrazol Elixir	15.0
Nyquil Cough Syrup	25.0
Mol Iron Liquid	4.75
Organidin Elixir	23.75
Ornacol Liquid	8.0
Tincture Paregoric	45.0
Parapectolin	0.69
Parelixir	18.0
Periactin Syrup	5.0
Pertussin 8 Hour Syrup	9.5
Phenergan Expectorant Plain	7.0
Phenobarbital Elixir	14.0
Phenergan Expectorant with Codeine	7.0
Phenergan Expectorant V.C., Plain	7.0
Phenergan Expectorant V.C., with Codeine	7.0
Phenergan Expectorant Pediatric	7.0
Phenergan Syrup Fortis (25 mg)	1.5
Polaramine Expectorant	7.2
P.B.Z. Expectorant with Ephedrine	6.0
Propadrine Elixir HC1	16.0
P.B.Z. Expectorant with Codeine and Ephedrine	6.0

Drug	Percentage of Alcohol
Quibron Elixir	15.0
Robitussin Syrup	3.5
Robitussin A.C. Syrup	3.5
Robitussin PE	1.4
Robitussin D.M. and Robitussin C.F.	1.4
Rondec D.M. Syrup and Drops	0.6
Roniacol Elixir	8.6
Serpasil Elixir	12.0
Tedral Elixir	15.0
Temaril Syrup	5.7
Terpin Hydrate Elixir	42.0
Terpin Hydrate Elixir with Codeine	42.0
Theo Organidin Elixir	15.0
Triaminic Expectorant	5.0
Triaminic Expectorant D.H.	5.0
Tussend Liquid	5.0
Tussar – 2 Syrup	5.0
Tussi–Organidin Expectorant	15.0
Tussar S.F. Syrup	12.0
Tuss–Ornade Liquid	7.5
Tylenol Elixir	7.0
Tylenol with Codeine Elixir	7.0
Tylenol Drops	7.0
Ulo–Syrup	6.65
Valadol Liquid	9.0
Valpin–PB Elixir & Valpin	5.3
Vita Metrazol Elixir	15.0
Vicks Formula 44	10.0
Potassium Chloride Sol. (Standard) (a no alcohol solution can be requested)	10.0

NOTE:
1. Mouthwashes – Scope, Listerine, Cepacol, Colgate 100, Micrin all have approximately 15–25%.
2. All elixirs contain some alcohol.
3. The following anti-tussives do not contain alcohol:
   - *Hycodan Syrup
   - *Hycomine Syrup
   - Triaminicol Syrup
   - *Tussionex Suspension
   - Orthoxicol Syrup
   - Actified C Expectorant
   - Omnituss
   - Ipsatol Syrup
4. Other non-alcoholic liquids:
   - Chloraseptic mouthwash/gargle
   - Liquiprin (acetaminophen)
   - Dilantin Suspension
   - Alupent Syrup
   - *Noctec Syrup
   - *Vistaril Suspension
   - Antacids
   - Kaopectate and Parget, etc.
   - Sudafed Syrup
   - *Quadrinal Suspension
   - Actifed Syrup
   - Triaminic Syrup
   - Naldecon Syrup
   - Nydrazid Syrup

*Ingestive medications may contain other addictive substances which may be considered.

BEST COPY AVAILABLE

MEDICATIONS CONTAINING ALCOHOL

(PERCENTAGE OF ALCOHOL SHOWN)

BENADRYL ELIXIR	14.0%
BENYLIN EXPECTORANT	5.0%
CAS-EVAC	18.0%
AROMATIC CASCARA SAGRADA	18.0%
CHLOR TRIMETON SYRUP	7.0%
DIMETANE ELIXIR	10.0%
DONNATAL ELIXIR	23.0%
ELIXIR THEOPHYLLINE	20.0%
GEVRABON LIQUID	18.0%
ISUPREL ELIXIR	19.0%
LIQUID LOMOTIL	15.0%
NEMBUTAL ELIXIR	18.0%
NYQUIL COUGH SYRUP	25.0%
TINCTURE PAREGORIC	45.0%
QUIBRON ELIXIR	15.0%
TEDRAL ELIXIR	15.0%
TERPIN HYDRATE ELIXIR	42.0%
TERPIN HYDRATE W/CODINE	42.0%
VICK'S FORMULA 44	10.0%

Food And Drug Interactions

If you're taking a drug, the food you eat could make it work faster or slower or even prevent it from working at all. Eating certain foods while taking certain drugs can be dangerous. And some drugs can affect the way your body uses food.

by Phyllis Lehmann

Would it occur to you not to swallow a tetracycline capsule with a glass of milk? Or to avoid aged cheese and Chianti wine if you are taking a certain medicine to combat hypertension? Or to eat more green leafy vegetables if you are on The Pill? Probably not. Yet the effects foods and drugs have on each other can determine whether medications do their job and whether your body gets the nutrients it needs.

The extent of interaction between foods and drugs depends on the drug dosage and on the individual's age, size, and specific medical condition. In general, though, the presence of food in the stomach and intestines can influence a drug's effectiveness by slowing down or speeding up the time it takes the medicine to go through the gastrointestinal tract to the site in the body where it is needed.

Food also contains natural and added chemicals that can react with certain drugs in ways that make the drugs virtually useless. Some reactions can be downright dangerous, triggering a medical crisis or, in rare instances, even death.

It is because of these interactions that your doctor tells you to take certain medications on an empty stomach, some just before meals, and some with meals.

A major way food affects drugs is by enhancing or impeding absorption of the drug into the bloodstream. There are a few cases in which foods speed up absorption. For example, blood levels of griseofulvin, a substance that combats fungus infections such as ringworm, rise markedly if the patient eats fatty foods before taking the drug.

More commonly, though, food and beverages interfere with absorption. A classic interaction is the one between tetracycline compounds and dairy products. The calcium in milk, cheese, and yogurt impairs absorption of tetracycline. On the other hand, taking some iron supplements with citrus fruits or juices which contain ascorbic acid enhances absorption of the iron.

In general, it is unwise to take drugs with soda pop or acid fruit or vegetable juices unless you check with your doctor first. These beverages can result in excess acidity that may cause some drugs to dissolve quickly in the stomach instead of in the intestines where they can be more readily absorbed into the bloodstream.

Some foods contain active substances which can cause a drug effect or which can interact with a drug to produce an unexpected or counter effect. For example, licorice extracted from natural sources contains a substance which, when consumed regularly in excess amounts, may cause an elevation in blood pressure. Licorice is a favorite ingredient in candy and a flavoring for some pharmaceuticals. Most American manufacturers now use a synthetic flavoring but many imported products still contain licorice from natural sources. Continued regular use of products containing natural licorice extract could aggravate high blood pressure or counteract the effect of medication for high blood pressure.

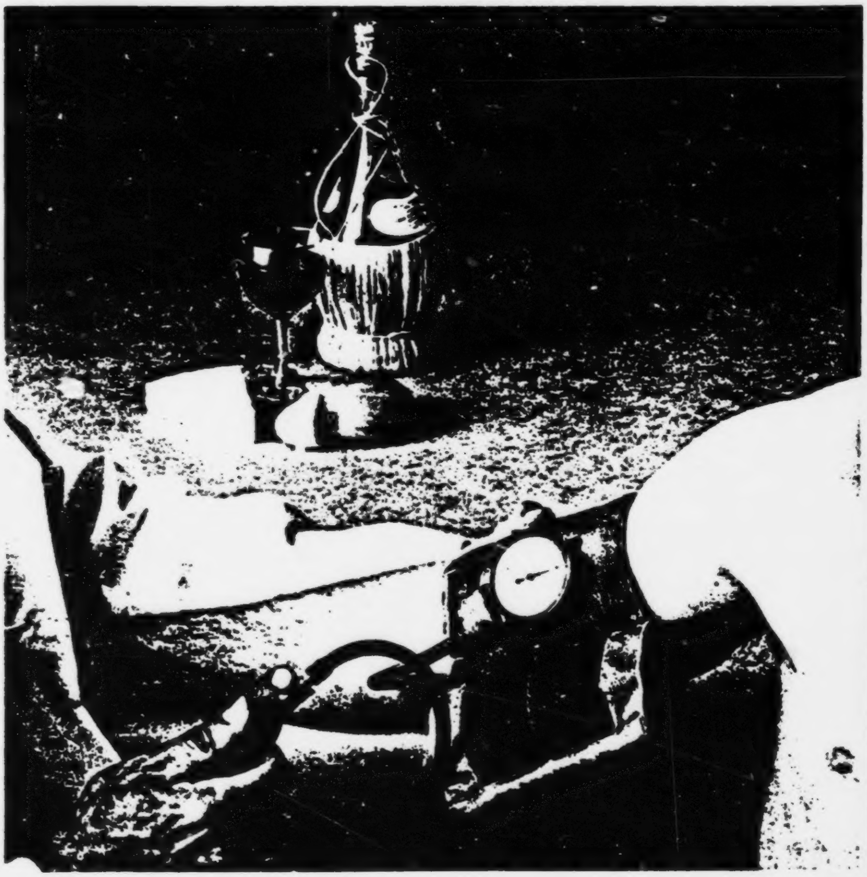
Excessive consumption of foods high in vitamin K, such as liver and leafy green vegetables, may hinder the effectiveness of anticoagulants. Vitamin K, which promotes clotting of the blood, works in direct opposition to these drugs, which are intended to prevent clotting.

Some foods, such as soybeans, rutabagas, brussels sprouts, turnips, cabbage, and kale, contain substances known as goitrogens which inhibit production of the thyroid hormone and thus can produce goiter. Scientists suggest caution in eating these foods when taking thyroid medications.

Perhaps the most hazardous food-drug interaction is the one between monoamine oxidase (MAO) inhibitors, drugs at times prescribed for depression and high blood pressure, and such foods as aged cheese, Chianti wine, and chicken livers. MAO inhibitors can react with a substance called tyramine in these foods and force the blood pressure to dangerous levels, sometimes causing severe headaches, brain hemorrhage, and, in extreme cases, death.

To prevent a possible reaction, anyone taking MAO inhibitor drugs should avoid aged and fermented foods, including pickled herring; fermented sausages, such as salami and pepperoni; sharp or aged cheeses; yogurt and sour cream; beef and chicken livers; broad beans, such as fava beans; canned figs; bananas; avocados; soy sauce; active yeast preparations; beer; Chianti wine, sherry, and other wines in large quantities. MAO inhibitors also are suspected of reacting adversely with cola beverages, coffee, chocolate, and raisins.

Alcohol, which is actually a drug itself, although not regulated as a drug under the Food, Drug, and Cosmetic Act, does not mix well with a wide variety of medications, such as antibiotics; anticoagulants; antidiabetic drugs, including insulin; antihistamines; high blood pressure drugs; MAO inhibitors; and sedatives. Alcohol combined with antihistamines, tranquilizers, or antidepressants causes excessive drowsiness that can be especially hazardous to someone driving a car, operating machinery, or performing some other task that requires mental



Perhaps the most hazardous food-drug interaction is the one between monoamine oxidase (MAO) inhibitors, drugs often prescribed for depression and high blood pressure, and such foods as aged cheese, Chianti wine, and chicken livers.

alertness. A good rule of thumb is to avoid alcoholic beverages when taking any type of prescription or over-the-counter medication.

Just as some foods can affect the way drugs behave in the body, so some drugs can affect the way the body uses food. Drugs may act in various ways to impair proper nutrition: by hastening excretion of certain nutrients, by hindering absorption of nutrients, or by interfering with the body's ability to convert nutrients into usable forms. Nutrient depletion of the body occurs gradually, but for those taking drugs over long periods of time these interactions can lead to deficiencies of certain vitamins and minerals, especially in children, the elderly, those with poor diets, and the chronically ill.

Some drugs inhibit nutrient absorption by their effect on the bowel wall. Among these are colchicine, a drug prescribed for gout, and mineral oil, an ingredient used in some over-the-counter laxatives.

A number of drugs affect specific vitamins and minerals. The antihypertension drug hydralazine and the antituberculosis drug INH can deplete the body's supply of vitamin B_6 by inhibiting production of the enzyme necessary to convert the vitamin into a form the body can use or by combining with the vitamin to form a compound that is excreted.

Similarly, anticonvulsant drugs that are used to control epilepsy can lead to deficiencies of vitamin D and folic acid because they increase the turnover rate of these vitamins in the body.

Quite a few drugs—for example, colchicine, oral antidiabetic agents, and the antibiotic neomycin—can impair absorption of vitamin B_{12}. But because most Americans have good stores of B_{12} in their livers, it takes prolonged ingestion of these drugs to cause a deficiency.

Long term use of diuretics, or "water pills," to treat such conditions as congestive heart failure, can lead to serious potassium depletion. If the potassium loss is not corrected in heart patients taking digitalis, the heart may become more sensitive to the effects of the drug. People taking diuretics regularly should eat foods which are good sources of potassium. These include tomatoes and tomato juice, oranges and orange juice, dried apricots, cantaloupes, figs, raisins, bananas, prunes, potatoes, sweet potatoes, and winter squash.

Modifying the diet to include more foods rich in the vitamins and minerals that may be depleted by certain drugs generally is preferable to taking vitamin or mineral supplements. In fact, supplements of some vitamins can counter the effectiveness of certain drugs.

Fortunately, the diets of most Americans are sufficiently well-balanced so that the threat of drug-related nutritional deficiencies can be easily overcome.

Because oral contraceptives are used so widely, their effect on nutrition has been getting increasing attention. The Pill is known to deplete the blood's content of certain vitamins, notably folic acid and vitamin B_6, but usually the vitamin depletion is not serious enough to cause overt symptoms. In most healthy women with good diets, these vitamin levels do not go down to a point that is alarming, says Dr. Daphne Roe, a Cornell University nutritionist. "But in a poverty group of young women who are trying to make do with very little and who have limited nutritional knowledge, you may find a different situation," Dr. Roe says. "It is this group we are most concerned about."

Because her requirements for several vitamins may be increased, it is especially important for any woman on The Pill to eat a nutritionally balanced diet. In particular, if a woman on The Pill is living on snack foods, she is more likely to develop folate deficiency than her neighbor who every day eats green leafy vegetables, which are a good source of folic acid, according to Dr. Roe.

Drugs readily available without prescription also can lead to nutritional problems. The worst offenders are antacids, Dr. Roe says, because they are so widely abused by the public. Chronic use of these remedies without a doctor's supervision can cause phosphate depletion, a condition that in its milder form produces muscle weakness and in more severe form leads to a vitamin D deficiency. "Unfortunately," says Dr. Roe, "some people get into the habit of taking enormous amounts of these drugs to treat gastric upset that in itself is due to their abuse of some other substance, such as alcohol, coffee, or food."

Mineral oil, an old-fashioned laxative still widely used by elderly people and in nursing homes, can hinder absorption of vitamin D. One study reported that as little as 20 milliliters (4 teaspoons) of mineral oil twice daily can interfere with absorption of vitamin D, vitamin K, and carotene, a substance the body converts to vitamin A.

What can consumers do to prevent undesirable food-drug interactions? Here are a few suggestions:

- Read the labels on over-the-counter remedies and the package inserts that come with prescription drugs.
- Follow your doctor's orders about when to take drugs and what foods or beverages to avoid while taking medications.
- Don't be afraid to ask how drugs might interact with your favorite edibles, especially if you consume large amounts of certain foods and beverages. While taking drugs, be sure to tell your doctor about any unusual symptoms that follow eating particular foods.
- Eat a nutritionally well-balanced diet from a wide variety of foods. Use of a needed drug, even on a long term basis, is less likely to cause depletion of vitamins and minerals if your overall nutritional status is good.

Drug labeling and informed health professionals can be helpful to you, but your doctor and pharmacist cannot follow you to the dinner table or the snack bar. Remember that warnings about food-drug interactions are only as good as the patient's willingness to heed them.

Phyllis Lehmann is a freelance writer

REPRINTED FROM MARCH 1978 **REVISED AUGUST 1984** **HHS Publication No. (FDA) 84-3070**

FDA CONSUMER

DEPARTMENT OF HEALTH AND
HUMAN SERVICES
Public Health Service
Food and Drug Administration
5600 Fishers Lane
Rockville, Md. 20857

☆ U.S. GOVERNMENT PRINTING OFFICE 1984-421-174/158

BLANK PAGE

Diet and the Elderly

by *Chris W. Lecos*

The fastest growing minority in the United States today is th elderly—those 65 or over. While the age marker may be ar arbitrary definition, it does define a population of men and women with unique and sometimes difficult health and nutritio problems.

Some statistics graphically illustrate the magnitude of concerns of those trying to meet the health needs of older Americans. There are some 26 million men and women in the United States today who are at least 65. That's 11.1 percent of th total population, yet these elderly account for:

- 29 percent of the country's health-care costs
- 25 percent of the prescription drugs used
- 15 percent of all visits to doctors' offices
- 34 percent of all days in short-stay hospitals

And, because Americans are living longer, the health-care demands associated with the "graying of America" can only increase. At the start of this century only one out of 25 persons reached the age of 65. Today, one in nine is attaining that mark. A child born in 1982 can be expected to live about 75 years, anc a person who was 65 that year could expect to live on the avera another 17 years. Some of the physical and even psychological changes a person experiences as he or she gets older are believ to be influenced by the habits of their lifetime—the foods eaten the amount of physical activity, smoking, drinking and drug taking. Other changes result from the aging process.

The aging process—how we get old and why—is something the experts admit they know little about. If anything is certain, is that aging is a biological process that begins at birth and continues to its undeniable, inevitable end.

Almost all the experts agree that nutrition is a factor in the aging process, although it is not really clear why. As one gets older, the chances of suffering a chronic illness are greater, anc health experts believe that poor eating habits contribute to som of those ailments. Conversely, changing eating habits to impro nutrient intake also is looked upon as a possible therapy for some conditions. But health experts do not know enough to tell the elderly just what they should be eating.

Dr. Myron Winick, director of the Institute of Human Nutrition at Columbia University's College of Physicians and Surgeons, summed it up this way: "Today there is not a single nutrient for which there is a recommended daily allowance for men and women 65 and older. Even worse, there is no data bas on which to formulate such recommendations. For the present any recommendations we make must be based on a combinatio of experimental results, clinical experience and logical deductions and so must be considered tentative."

The best information available today on nutritional requirements for the general population is that of the Food and Nutrition Board of the National Academy of Sciences/National Research Council. Its recommended dietary allowances for pr tein, 10 vitamins and six minerals are based on the board's research reviews. However, since these are estimates for the general population, the intake levels are set high enough to co the needs of most healthy persons in the United States.

As a person gets older, the rate at which the body uses energ tends to decrease. Food intake generally is lower, and the amount of lean body tissue decreases while the amount of bod fat increases.

The eating habits of older people also may be adversely affected by reduced vision, decreased senses of smell and taste, loneliness, depression, poor teeth, illness, income limitations, and increased alcohol and medicine use. If food doesn't look or smell as good, appetite may diminish. Many older people compensate for taste loss by eating more highly seasoned foods, which can lead to salt overuse. Poor teeth and gums may make chewing more difficult, which results in diets limited to foods that are easy to chew but that may be lacking in essential nutrients.

The gastrointestinal tract, through which all food passes to be digested and absorbed, also undergoes changes as a person gets older. Hydrochloric acid secretion in the stomach generally decreases with age; this can interfere with digestion.

Changes in the intestinal tract also can result in reduced intestinal absorption of some nutrients, including proteins, carbohydrates, fats, vitamins and minerals. Further, the kidneys, which must excrete waste products, become less effective.

These and other factors suggest that the elderly do have special dietary requirements and that some of them may need more of certain nutrients than they did when they were younger. A growing amount of research into the way the elderly eat and live is expected to produce new recommendations on their specific nutrient needs.

Research already points to lack of calcium in the diet as a factor in osteoporosis, a disease that leaves the bones brittle and prone to fractures. Osteoporosis afflicts far more women than men, and calcium supplements often are recommended for postmenopausal women.

Generally, bone strength increases until about the age of 30 to 35. Following menopause, the amount of bone loss in women tends to accelerate for three to seven years, possibly as a result of decreased estrogen levels. As people get older—especially women—they tend to consume fewer calcium-rich foods such as milk, cheese and other dairy products. The situation may be further aggravated by reduced physical activity as a person ages. Bone renewal is aided by exercise.

Another mineral that may be inadequate in some elderly people is zinc, which is essential for various metabolic processes. The healing of wounds and the body's immune response—that is, its ability to resist disease and infection—can be impaired if zinc is not consumed in adequate amounts. But severe zinc deficiency is rare in this country. Meat, seafood and eggs are especially good sources of zinc.

Because they are concerned about dietary needs, many older Americans are susceptible targets for a wide variety of products for which false nutritional claims are made. Some may need to take vitamin or mineral supplements, but that determination should be based on sound medical advice. Unnecessary and ill-advised purchases of supplements not only deprive an older person of funds that could be spent for foods essential to good health, but they also can lead to excessive—and potentially toxic—intake of certain vitamins and minerals.

Certain diseases and other health problems may require supplements. Already noted is the use of calcium supplements for older women to prevent osteoporosis. Some elderly people recuperating from surgery or suffering from some illnesses common to older people also may need a dietary boost by taking nutrient supplements. But that's a decision only a doctor should make.

The use of "megavitamins"—large amounts of individual nutrients or combinations—concerns many scientists because large doses of some nutrients can have serious effects. Vitamins A and D are essential to good health but in large amounts can be harmful. An excess of vitamin A can cause headaches, nausea, diarrhea and, eventually, liver and bone damage. High doses of vitamin D can cause kidney damage in adults. Excessive amounts of iron also can build up to harmful levels in the liver and other body organs in some individuals.

Some supplements—like the misnamed "vitamin B_{15}" (or "pangamic acid")— are valueless despite claims made for them. Pangamic acid sometimes is promoted as a treatment for heart disease, diabetes, glaucoma, allergies and other ailments. It is not a vitamin and has no known medical usefulness. Another unnecessary supplement sold in pill form is superoxide dismutase (SOD), sold as an "anti-aging" pill. Its usefulness as a diet supplement was given some credence—wrongly—after scientists discovered that animals with long lifespans have more of the enzyme in their bodies than those that live shorter lives.

Nutrition experts generally stress that a well-balanced diet will provide most elderly men and women who are in good health—in fact, most people of all ages— with the nutrients they need for healthy living. A proper diet, the National Institute on Aging advises, should include:

- at least two servings of milk or other dairy products (such as cheese, cottage cheese or yogurt)
- two servings of high-protein foods (such as lean meat, poultry,

fish, eggs, dried beans, nuts or peanut butter)
- four servings of fruits and vegetables, including citrus fruit or juice and a dark-green leafy vegetable
- four servings of bread or cereal products made with whole-grain or enriched flour, rice or pasta.

While food is essential for life, drugs are important, too, when used to treat or prevent illness. Mixed together, however, foods and drugs can interact in ways that can diminish a drug's effectiveness or deprive the body of the nutrients it is receiving. In some instances, certain drug-food combinations can produce serious illness, even death.

Although food and drug interactions can occur in people of any age, they pose particular problems for the elderly, who are major users of prescription and over-the-counter drugs. Studies show that more than half of the elderly are taking at least one medication a day, and many are taking six or more. What is more significant, they are less likely than younger patients to be well-informed about how and when to take these drugs.

Food can have both short and long-term effects on the way drugs behave in the body. It can speed up or slow down the absorption of a drug, influence the time it takes for the drug to pass through the gastrointestinal tract, and alter the way in which it is metabolized for use in the body. (There are times, however, when drugs have to be taken with food or a beverage to help prevent gastrointestinal upset.)

Alcohol can interact with other drugs. When drunk in excess, it can play havoc with human health. Intoxication can occur more rapidly when alcohol and certain medications are taken together. Consumed with tranquilizers, barbiturates, painkillers and antihistamines, alcohol can compound the depressant effects of those drugs on the central nervous system. Performance skills, judgment and alertness can be slowed considerably.

Alcohol also can cause other drugs—anticonvulsants and anticoagulants, for example—to be metabolized more rapidly, producing exaggerated responses. Alcohol can raise blood sugar levels and interfere with drugs prescribed for those with diabetes, a common disease of the elderly. With monoamine oxidase (MAO) inhibitors, which are prescribed for depression and high blood pressure, alcohol can spark sharp increases in blood pressure. With diuretics, it can reduce blood pressure, causing dizziness. With antibiotics, it can produce nausea, vomiting, headaches and stomach cramps. Alcohol also may destroy the coating of timed-release capsules, causing more rapid absorption of a drug. The conclusion is obvious: Don't drink while taking drugs unless a doctor gives specific approval.

Certain drugs also may promote dietary deficiencies. Antacids, aspirin and laxatives are examples. Antacids contain aluminum hydroxide, which can contribute to phosphate deficiency. Aspirin, which is the drug of choice for treating arthritis, can cause small amounts of bleeding in the gastrointestinal tract. Such bleeding can lead to iron depletion. A person taking lots of aspirin may need to follow a diet high in iron.

Some studies suggest that aspirin competes with folic acid for a place in the protein molecule in blood that transports this nutrient to the tissues. Studies also suggest aspirin may increase the elimination of folic acid in urine. Long-time aspirin users thus may need diets high in folic acid as well as iron. Chronic aspirin users also may need additional vitamin C.

Constipation is a chronic complaint of the elderly, and many older people seek relief with laxatives. While doctors do not always know what causes constipation, poor diet as well as inadequate consumption of fluids, misuse of laxatives, and lack of exercise may contribute to it. Certain drugs—like antidepressants, antacids containing aluminum or calcium, and diuretics—also may cause it.

Laxatives can adversely affect nutrient intake. Some affect vitamin D absorption, which in turn can make a poor calcium balance even worse. A laxative containing mercury can cause depletion of phosphorus from the bones. Mineral oil, a widely used constipation remedy, can interfere with the absorption of vitamins A, D, E and K, and it can interfere with anticoagulants (given to prevent blood clots).

Clearly, there is much the elderly need to know about their medications. Yet, surveys show that patients often are lacking information about the medicines prescribed for them. The elderly, who take three times as many medications as the population in general, should find out as much as possible about their medications, especially proper use and side effects.

Few drugs have been tested specifically on the elderly. But more testing is being done, just as more is being learned almost daily about nutrition and the elderly.

Chris W. Lecos is a member of FDA's communications staff.

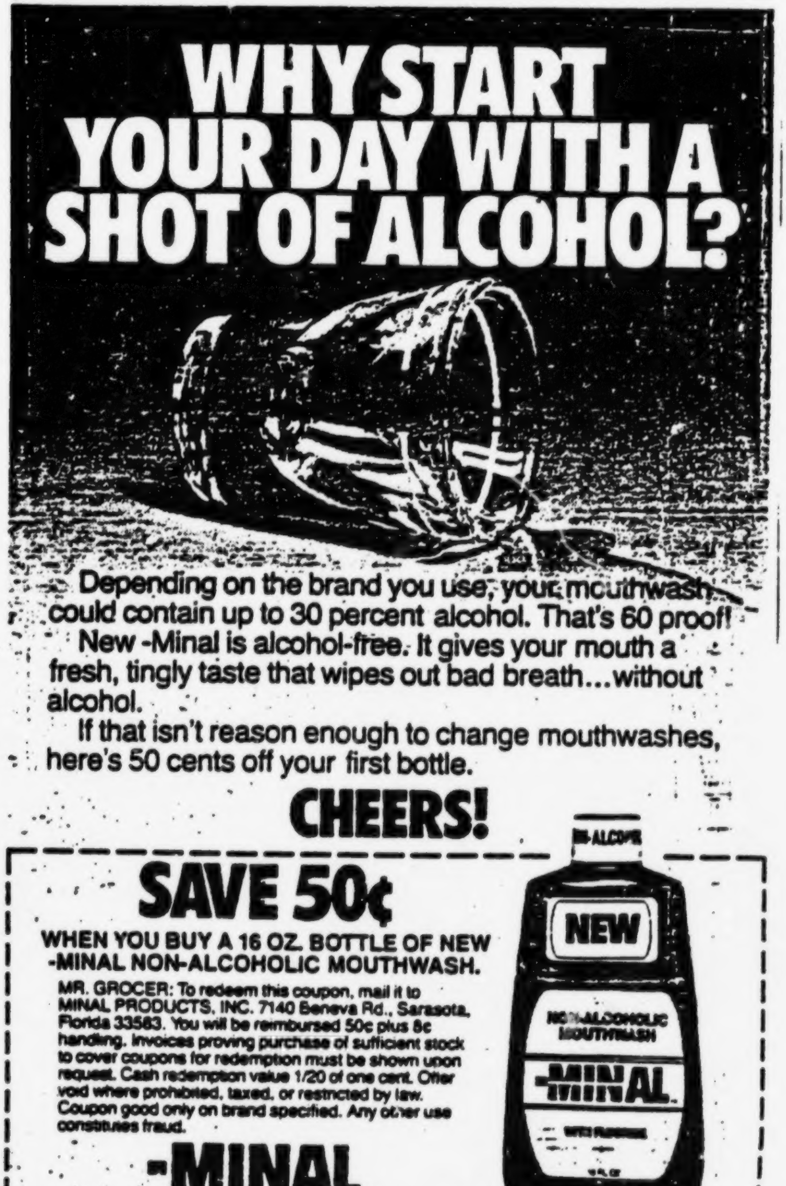
REPRINTED FROM DECEMBER 1984-JANUARY 1985 HHS Publication No. (FDA) 85-220

FDA CONSUMER

DEPARTMENT OF HEALTH AN
HUMAN SERVICES
Public Health Service
Food and Drug Administration
5600 Fishers Lane
Rockville, Md. 20857

☆U.S. GOVERNMENT PRINTING OFFICE 1986-491-341/40040

BLANK PAGE


NON-ALCOHOLIC
NEW
NON-ALCOHOLIC MOUTHWASH
-MINAL

WHY START YOUR DAY WITH A SHOT OF ALCOHOL?

Depending on the brand you use, your mouthwash could contain up to 30 percent alcohol. That's 60 proof!

New -Minal is alcohol-free. It gives your mouth a fresh, tingly taste that wipes out bad breath... without alcohol.

If that isn't reason enough to change mouthwashes, here's 50 cents off your first bottle.

CHEERS!

SAVE 50¢

WHEN YOU BUY A 16 OZ. BOTTLE OF NEW -MINAL NON-ALCOHOLIC MOUTHWASH.

MR. GROCER: To redeem this coupon, mail it to MINAL PRODUCTS, INC. 7140 Beneva Rd., Sarasota, Florida 33583. You will be reimbursed 50¢ plus 8¢ handling. Invoices proving purchase of sufficient stock to cover coupons for redemption must be shown upon request. Cash redemption value 1/20 of one cent. Offer void where prohibited, taxed, or restricted by law. Coupon good only on brand specified. Any other use constitutes fraud.

-MINAL.

AVAILABLE AT: Phar-Mor, Kash n' Karry, Family Mart, U-Save and your neighborhood pharmacy.

Tampa Tribune - April 1986

BLANK PAGE

ESTIMATES OF ELDERLY ALCOHOL ABUSERS:

20% OF MEDICAL INPATIENTS

30 - 40% IN PSYCHIATRIC FACILITIES

10% TO 15% OF ELDERLY IN THE COMMUNITY

BEST COPY AVAILABLE

BLANK PAGE

REASONS FOR CONCERN:

I. THE POPULATION IS "AGING"

U.S. POPULATION OF THOSE 55 & OLDER:

1960 - 32 MILLION OR 17%

1980 - 46 MILLION OR 20%

2000 - 55 MILLION OR 20%

II. ELDERLY HAVE DIFFICULTY ACCESSING SERVICES

III. CAREGIVER'S HESITANCE TO LABEL ELDERLY AS ALCOHOL ABUSERS; INABILITY TO PAY.

IV. SYMPTOMS CAN MIMIC AGE RELATED BEHAVIOR CHANGES

V. LITTLE KNOWN ABOUT THE OLDER DRINKER.

BLANK PAGE

TWO TYPES OF ELDERLY ALCOHOL ABUSERS:

EARLY ONSET OR LONG TERM

WELL DEVELOPED BEHAVIORAL PROBLEMS
MORE PHYSICAL HEALTH PROBLEMS
WELL KNOWN TO SERVICE DELIVERY SYSTEM

LATER-LIFE ONSET OR REACTIVE -

ONSET RELATED TO AGE RELATED PROBLEMS & RECENT LOSSES:

DEATH OF SPOUSE
RETIREMENT
PHYSICAL ILLNESS
REDUCED SOCIAL SUPPORTS

BLANK PAGE

HOW DO YOU KNOW AN ALCOHOL PROBLEM EXISTS?

MANY CONSIDER ONLY THE QUANTITY/FREQUENCY OF ALCOHOL CONSUMPTION - HOWEVER THIS IS HIGHLY SUBJECTIVE AND VARIABLE

SOME SAY "WHEN ALCOHOL HAS TAKEN CONTROL OVER ONE'S LIFE" - BUT HOW CAN WE DEFINE "CONTROL" ?

THERE IS NO RELIABLE DEFINITION FOR:

ALCOHOLIC
ALCOHOLISM
PROBLEM DRINKER

HOW CAN WE KNOW THAT A PROBLEM EXISTS?

BLANK PAGE

"QUALITY OF LIFE INDICATORS":

THEY CAN BE THE ANTECEDENT OR THE CONSEQUENCE OF THE ALCOHOL ABUSE

1. PHYSICAL/MEDICAL PROBLEMS
2. LEGAL PROBLEMS
3. FINANCIAL & OCCUPATIONAL PROBLEMS
4. FAMILY/RELATIONSHIPS
5. MENTAL HEALTH

IF ONE OR MORE OF THESE INDICATORS IS RELATED TO ALCOHOL CONSUMPTION, THEN WE CAN SAY A PROBLEM EXISTS

BLANK PAGE

PLANNING ALCOHOL TREATMENT
A THREE STAGE PROCESS:

1. DETERMINE EACH INDIVIDUAL'S "HIGH RISK" SITUATIONS

2. TEACH EACH PERSON TO UNDERSTAND HIS/HER PERSONAL HIGH RISK SITUATIONS

3. TEACH SKILLS SPECIFIC TO THESE HIGH RISK SITUATIONS

GOAL: PREVENT RELAPSE

BLANK PAGE

KEY QUESTIONS TO DETERMINE HIGH RISK SITUATIONS:

1. WHAT ARE THE ANTECEDENTS TO DRINKING?

   PRECEDE FIRST DRINK ON A GIVEN DAY.

2. DRINKING BEHAVIOR

3. WHAT ARE THE CONSEQUENCES?

SHORT TERM OR IMMEDIATE	LONG TERM
(+) (-)	(-)

THE "DRINKING BEHAVIOR CHAIN"

OR "THE A-B-C's"

BLANK PAGE

WHAT ARE THE ANTECEDENTS?

1. WHERE & WHEN DOES THE PERSON DRINK ON A TYPICAL DAY OF DRINKING?

2. WHAT IS HE OR SHE DOING JUST BEFORE TAKING THE FIRST DRINK?

3. WHAT DOES HE/SHE THINK ABOUT PRIOR TO THE FIRST DRINK?

4. WHAT FEELINGS ARE EXPERIENCED PRIOR TO THE FIRST DRINK?

5. WHAT PHYSICAL REMINDERS OR CUES ARE PRESENT TO REMIND THE PERSON TO DRINK?

6. WHAT DOES THE PERSON SAY TO SELF JUST BEFORE CONSUMING THE DRINK?

- THE "URGE"

BLANK PAGE

CONSEQUENCES TO DRINKING

	POSITIVE	NEGATIVE
SHORT TERM OR IMMEDIATE	FEEL FRIENDLY RELAXED STRONG	ARGUE WITH SPOUSE GET SLEEPY UPSET STOMACH
LONG TERM	N O N E	IMPAIRED HEALTH MARITAL PROBLEMS PROB. ON THE JOB BLACKOUTS

BEST COPY AVAILABLE

BLANK PAGE

THE DRINKING BEHAVIOR CHAIN:

SITUATIONS/THOUGHTS + FEELINGS + CUES + URGES --->

(ANTECEDENTS)

DRINKING ------>

(BEHAVIOR)

SHORT TERM OR IMMEDIATE	LONG TERM
(+) (-)	(-)

(CONSEQUENCES)

BLANK PAGE

THE G.A.P. DRINKING PROFILE

I. FAMILY DRINKING HISTORY

II. PERSONAL DRINKING HISTORY

III. PRESENT DRINKING PATTERN

IV. ANTECEDENTS TO DRINKING

V. CONSEQUENCES OF DRINKING

VI. MOTIVATION FOR TREATMENT

BLANK PAGE

KEY QUESTIONS FOR INDIVIDUALIZED TREATMENT PLANNING:

FOCUSING ON THE 30 DAY PERIOD BEFORE THE LAST DRINK:

1. WHERE DO YOU USUALLY DRINK?

2. WITH WHOM DO YOU DRINK?

3. IN WHAT ACTIVITY ARE YOU TYPICALLY INVOLVED?

4. WHAT FEELINGS DO YOU EXPERIENCE BEFORE THE FIRST DRINK ON A TYPICAL DAY OF DRINKING?

5. WHAT CUES OR REMINDERS ARE PRESENT? (examples: beer commercials, seeing others drink, liquor in cabinet, passing a certain bar).

6. WHAT DO YOU SAY TO YOURSELF IMMEDIATELY BEFORE TAKING THE FIRST DRINK? (URGE) (e.g. "A good cold beer would make me feel better").

BLANK PAGE

KEY QUESTIONS FOR INDIVIDUALIZED TREATMENT PLANNING:

FOCUSING ON THE FIRST DRINK ON A TYPICAL DAY OF DRINKING DURING THAT 30 DAY PERIOD:

1. WHAT BEVERAGE DO YOU TYPICALLY CONSUME FIRST? HOW MUCH?
2. WHAT TIME OF THE DAY DO YOU DRINK?
3. HOW DO YOU OBTAIN IT? COST?
4. ADDITIONAL TIMES, BEVERAGES CONSUMED AFTER FIRST DRINK?
5. HOW OFTEN INTOXICATED DURING THE 30 DAYS?
6. HOW OFTEN NOT INTOXICATED? WHEN? WHY? WHAT MAKES YOU NOT DRINK?

BLANK PAGE

KEY QUESTIONS FOR INDIVIDUALIZED TREATMENT PLANNING:

FOCUSING ON THE CONSEQUENCES OF THE FIRST DRINK, ON A TYPICAL DAY OF DRINKING DURING THAT 30 DAY PERIOD:

1. WHAT FEELINGS DO YOU EXPERIENCE AFTER THE FIRST DRINK?

2. WHAT OTHER CONSEQUENCES CAN YOU DESCRIBE? (e.g. arguments with spouse, sleepiness, etc.)

3. WHAT HAPPENS AFTER PROLONGED DRINKING ON A TYPICAL DAY?

BLANK PAGE

TEACHING BEHAVIOR ANALYSIS TO ELDERLY ALCOHOL ABUSERS:

GENERAL RULES:

1. Smaller amounts of information in each session, compared to younger clients.

2. Repetition - consistent reviews.

3. Avoid confrontation, use praise and positive approaches first.

4. Quiz for comprehension. (Behavior Rehearsal, Written, Verbal)

BLANK PAGE

TEACHING BEHAVIOR ANALYSIS TO ELDERLY ALCOHOL ABUSERS:

THE "A-B-C's" of DRINKING
OR
'TAKING THE MYSTERY OUT OF DRINKING BEHAVIOR"

1. DEFINE ANY BEHAVIOR IN TERMS OF: ANTECEDENTS, BEHAVIOR, CONSEQUENCES

2. IDENTIFY PERSONAL ANTECEDENTS & CONSEQUENCES (USING INFORMATION FROM THE GAP DRINKING PROFILE).

3. QUIZZES ON KNOWLEDGE OF PERSONAL ANTECEDENTS & CONSEQUENCES.

4. FINAL STAGES: BEGIN MONITORING OF DRINKING BEHAVIOR - "LOGGING".

5. USE PERSONAL "CONSEQUENCES CARD" IF URGE TO DRINK BECOMES TOO STRONG.

BLANK PAGE

When the individual understands his/her personal drinking behavior chain, they are then ready to the learn skills to deal with future problems:

SELF-MANAGEMENT SKILLS

SKILLS FOR PERSON TO MODIFY THEIR OWN BEHAVIOR.

SKILLS MUST ADDRESS PERSONAL ANTECEDENTS TO DRINKING

THE THERAPIST BECOMES A TEACHER (instead of a modifier).

SKILLS TO PREVENT RELAPSE.

BLANK PAGE

SELF-MANAGEMENT SKILLS

TEACHING IS ACCOMPLISHED BY:

1. BEHAVIOR REHEARSALS - SIMULATING ACTUAL SITUATIONS.
2. LEARN SELF-MONITORING OF YOUR OWN BEHAVIOR (USING LOGS).
3. BEHAVIORAL CONTRACTS - WITH BUILT IN REWARDS, PUNISHMENT.
4. ASSIGNMENTS (HOMEWORK) FROM THE THERAPIST (TRAINER).

SELF-MANAGEMENT SKILLS MUST BE SPECIFIC TO EACH PERSON'S ANTECEDENTS.

BLANK PAGE

SELF-MANAGEMENT SKILLS FOR THE ELDERLY ALCOHOL ABUSER

HIGH RISK SITUATION	SKILLS TAUGHT:
SOCIAL PRESSURE	DRINK REFUSAL
LONELINESS	REBUILD SOCIAL NETWORK
DEPRESSION	COGNITIVE RESTRUCTURING THOUGHT-STOPPING
ANXIETY	RELAXATION, PROB. SOLV., THOUGHT-STOPPING
ANGER/FRUSTR.	ASSERTION TRAINING
CUES	HOW TO DISPOSE, AVOID, REARRANGE CUES
URGES	THOUGHT-STOPPING, LEARN TO DELAY
SLIPS	RELAPSE TRAINING -

BLANK PAGE

SELF-MANAGEMENT

DEALING WITH SOCIAL PRESSURE (SUBTLE OR OVERT):

- FEAR OF OTHERS' REACTIONS
- NEED TO BE FRIENDLY
- NEED TO FEEL PART OF SOCIETY

LEADS TO DECISION TO SAY "YES"
AND TO HAVE A DRINK

SOCIAL + FEELINGS + CUES --->"YES"---> DRINK
PRESSURE

BLANK PAGE

HOW TO "BREAK" THE CHAIN AT THE EARLIEST POINT:

1. AVOID ALL POTENTIAL DRINKING SITUATIONS - (DIFFICULT TO DO)

OR

2. LEARN SKILLS TO SAY "NO" TO THE DRINK, BUT YES TO FRIEND

TEACHING HOW TO REFUSE A DRINK

1. LOOK AT THE PERSON.
2. SAY "NO".
3. BE FIRM.
4. CHANGE SUBJECT OR SUGGEST AN ALTERNATIVE ACTIVITY
5. IF FRIEND PERSISTS, ASK FOR A CHANGE IN BEHAVIOR IN FUTURE.

Practice in treatment setting;
try out in actual settings.

BLANK PAGE

ANGER & FRUSTRATION

IF WE FOCUS ONLY ON LEARNING NOT TO DRINK - THE PERSON CAN REMAIN PASSIVE OR AGGRESSIVE

WHAT WILL HAPPEN IN THE NEXT ANGER PROVOKING OR FRUSTRATION SITUATION?

To minimize anger or frustration, we can teach more effective ways to communicate:

BEING ASSERTIVE

BLANK PAGE

RESOLUTION OF ANGER/FRUSTRATION

THE "D-E-S-C" MODEL

1. DESCRIBE OBJECTIONABLE BEHAVIOR OF THE OTHER PERSON

2. EXPRESS YOURSELF (eye contact, voice, posture, content)

3. SPECIFY - (request a change, compromise, persist, say no)

4. CONSEQUENT - (positive ones of changing and negative ones of not changing/compromising)

BLANK PAGE

TENSION & ANXIETY MANAGEMENT

BREAK THE CHAIN DURING THE SITUATION (feeling) OR THE "URGE"

ONE CAN LEARN TO AVOID ANXIETY PRODUCING SITUATIONS

OR

LEARN ANXIETY/TENSION REDUCTION

BLANK PAGE

STEPS TO MANAGE ANXIETY AND TENSION:

1. RECOGNIZE the signs (muscles, heartbeat, stomach, silent worriers)

2. STOP ruminative THOUGHTS

3. Make POSITIVE SELF-STATEMENT

4. LEARN TO RELAX.

5. PROBLEM SOLVE

BLANK PAGE

CUES FOR DRINKING

THE PERSON MUST BE MADE AWARE OF THE CONCRETE STIMULI WHICH REMIND HIM/HER ABOUT DRINKING

EXAMPLES:

ALCOHOL ITSELF

PLACES (bars, restaurants)

HEARING OTHERS DISCUSS IT

INDIRECT CUES SPECIFIC TO YOU:
- watching TV, football, etc.
- sitting in a favorite chair
- reading
- gambling
- certain times of the day
- special events, holidays

BLANK PAGE

CONTROLLING CUES:
(THE C-A-R-D MODEL)

1. COMPETING RESPONSE

2. AVOID (certain people, bars, certain social groups)

3. REARRANGE cues, schedule, lifestyle, remove favorite chair)

4. DISPOSE of alcohol, cues; keep it away from home, car, work; don't "test" yourself by having it available.

BLANK PAGE

THE URGE TO DRINK

The end of the antecedent part of the Drinking Behavior Chain

A strong desire for alcohol

It has a BEGINNING and an END if you do not drink.

It lasts different amounts of time.

It can be waited out successfully.

The more times you resist it, the easier it will be the next time (less strong and won't last as long the next time).

You can successfully wait out an urge. You need time to get your thoughts on something else and support from others.

BLANK PAGE

WHAT TO DO IF YOU HAVE THE URGE TO DRINK:

1. REMEMBER YOUR CONSEQUENCES

2. REMOVE ALL DRINKING CUES.

3. FIND SOMETHING ELSE TO DO - INCOMPATIBLE WITH DRINKING.

4. IF REACTING TO FEELINGS - (ANGER, TENSION, DEPRESSION) USE YOUR SKILLS TO MANAGE THEM!

5. IF THE URGE PERSISTS CALL FOR HELP!

REMEMBER:

All urges have a beginning & an end, even if you do not drink.

BLANK PAGE

RELAPSE TRAINING: HOW TO HANDLE A "SLIP"

ONE SLIP DOES NOT A BINGE MAKE!

"One drink, one drunk" is a myth.

- you can stop

- Some people are victims of myth of loss of control - consider themselves "doomed".

- Self-fulfilling prophecy.

ABSTINENCE VIOLATION EFFECT

BLANK PAGE

HOW TO HANDLE A "SLIP"

1. "I CAN STOP"
2. GET OUT OF DRINKING SITUATION
3. GET RID OF THE ALCOHOL
4. CALL FOR HELP. (hotline, phone number of AA sponsor, phone number of a nondrinking friend).

BLANK PAGE

PRESCRIPTION MEDICATION AND THE ELDERLY

THE MAJORITY OF ELDERLY CONSUME 5 OR MORE PRESCRIBED MEDICATIONS.

75% TAKE AT LEAST ONE PRESCRIBED MED.

THOSE IN COMMUNITY CONSUME 10.7 (AVG) PRESCRIBED MEDICATIONS/YEAR -------

INCREASING TO 14.2 IF TAKING AT LEAST ONE PRESCRIPTION & INCREASES FURTHER FOR THOSE ON SUPPLEMENTAL INSURANCE.

OVER THE COUNTER MEDICATIONS AND THE ELDERLY

CONSUMED BY UP TO 75% OF ELDERLY

ACCOUNT FOR ONE THIRD OF EXPENDITURES OF THEIR MEDICATIONS.

BLANK PAGE

IDENTIFYING POLYPHARMACY:

(SIMONSON, 1984)

(EXCESSIVE & UNNECCESARY USE OF MEDS.)

1. Use of meds. that have no apparent indication (need re-evaluation)

2. Use of duplicate meds. (e.g. 2 or more sedatives)

3. Concurrent use of interacting meds.

4. Use of contraindicated meds. (allergic reactions; increase cardiac problems)

5. Use of inappropriate dosages - (should be reduced levels; few M.D.s are trained in geriatrics)

6. Use of Drug Therapy to treat adverse drug reactions ("spiralling" effect)

7. Improvement following Discontinuation of meds. - (need to start from scratch)

BLANK PAGE

CONSEQUENCES OF POLYPHARMACY

1. Adverse Drug Reactions
2. Drug Interactions
3. Financial Burden
4. Diagnostic Consequences
5. Decreased Sensorium

BLANK PAGE

NONCOMPLIANCE:

The failure of patients to follow instructions provided, regarding the use of meds. (Hussar, 1975).

Estimated in noncompliance studies (1968-79) between 2% & 95% of elderly.

Simonson (1984) estimates at least one fourth to one third of elderly outpatients exhibit some form of it.

BLANK PAGE

TYPES OF NONCOMPLIANCE:

(SIMONSON, 1984)

1. Failure to take medication.
2. Taking meds. at wrong time.
3. Excessive consumption (purposely or inadvertently).
4. Discontinuing meds. prematurely
5. Failure to fill precription.
6. Consumption of interfering meds., nutrients, or alcohol.
7. Use of meds. not prescribed ("leftovers"; "gifts").

BLANK PAGE

REASONS FOR NONCOMPLIANCE:

(SIMONSON, 1984)

PATIENT RELATED FACTORS:

1. Not understanding Drug Therapy
2. Self-Medicating Practices
3. Lack of Social Supervision.
4. Too ill or tired to take meds.
5. Sensory Losses (affects ability to understand written or verbal instructions)

BLANK PAGE

REASONS FOR NONCOMPLIANCE:

THERAPY RELATED FACTORS:

1. Complex Drug Therapy (as the number of drugs increase, compliance decreases).
2. Adverse Drug Effects
3. Dosage Form - Difficulty to use the meds.
4. Financial Consideration
5. Characteristics of Illness (misperceptions that a lack of severe symptoms indicate no need for meds.)

FACTORS RELATED TO HEALTH PROFESSIONALS:

1. Develop positive patient relationship, attitude toward therapy, indicate confidence in medication.
2. Patient Education - patients should be taught reasons, consequences, instructions.

BLANK PAGE

TRAITS OF NONCOMPLIANT INDIVIDUALS

(Haynes, 1979; Haynes et al., 1970)

Illness fails to respond to therapy.

Patient is socially isolated.

Patient is forgetful or confused.

Patient fails to keep appointments.

Drug therapy is complex.

Patient fails to obtain timely prescription refills.

BLANK PAGE

ENCOURAGING PROPER COMPLIANCE

(SIMONSON, 1984)

1. Simplify drug therapy, regimens
2. Provide proper patient education
3. Use special medication packaging & labeling techniques.
4. Use compliance aids.
5. Avoid child proof containers.

BLANK PAGE

PHARMACOKINETICS OF AGING:

(What happens to meds. after they are consumed by an elderly person)

I. AGE RELATED CHANGES AFFECTING DRUG ABSORPTION:

A. Increase in gastric emptying time.

B. Decrease in intestinal motility.

C. Decrease in gastric acid production.

D. Decrease in intestinal blood flow.

E. Decrease in capacity to absorb drugs (cells decrease).

BLANK PAGE

II. AGE RELATED CHANGES AFFECTING DRUG DISTRIBUTION:

A. Changes in body size
(affects "usual" dose for an adult)

B. Changes in body composition
(increase in body fat affects fat soluble drugs.)

C. Protein bonding (decreased albumin in bloodstream allows for more "unbound" drug)

III. CHANGES IN DRUG METABOLISM

(decrease in liver blood flow, mass, enzyme activity may result in drugs being metabolized to active or inactive water soluble metabolites)

IV. CHANGES IN DRUG EXCRETION

(Ability to eliminate certain meds. decreases 50% or more).

BLANK PAGE

It is helpful in the presentation of the materials on psychotropic medications to present a brief historical review of mental health care. This permits the opportunity to place the use of psychotropic medication in perspective--as their development allowed for many of the changes in mental health treatment.

The hospital practice of psychiatry has changed remarkably in the past two decades. Since 1955, when the drugs first had widespread impact, the number of hospital beds occupied by psychiatric patients has steadily declined.

Aside from changes in numbers of patients in mental hospitals, hospitals themselves underwent remarkable changes. From being prisons, they became true hospitals. Hospital personnel who once devoted their time to custodial care are now able to participate in therapy.

References

Hollister, L. (1973). Clinical use of psychotherapeutic drugs. Illinois: Charles C. Thomas.

BLANK PAGE

PSYCHOTROPIC MEDICATIONS

Name: ______________________________ Date: ________________

CIRCLE THE CORRECT ANSWER.

1. The introduction of psychotropic drugs resulted in:

    a. diagnostic evaluation becoming unnecessary
    b. mental illness becoming more amenable to treatment
    c. psychotherapy and behavioral therapy becoming outmoded

2. A list of drug side effects can be found in:

    a. DSM III (Diagnostic and Statistical Manual)
    b. ICD-9 (International Classification of Diseases)
    c. PDR (Physicians Desk Reference)

3. A decision to prescribe psychotropic medication should be made after:

    a. the staff requests them to control patients' behavior
    b. the patient refuses psychotherapy
    c. consideration that the benefits outweigh the risks of the side effects

4. Dry mouth, constipation, and urinary retention are examples of:

    a. tachycardia
    b. anticholinergic effects
    c. extrapyramidal effects

5. MAO Inhibitors are indicated in:

    a. atypical depression
    b. bipolar disorders
    c. schizophrenia

6. Thorazine and Haldol are examples of

    a. antidepressants
    b. anxiolitics
    c. antipsychotics

7. Tardive Dyskinesia is a side effect of:

    a. antipsychotic medication
    b. antidepressants
    c. minor tranquilizers

8. Mania is treated by:

   a. Valium
   b. Ludiomil
   c. Lithium

9. Minor tranquilizers are used to treat:

   a. depression
   b. anxiety
   c. schizophrenia

10. Prescribed dosages of psychotropic medications for the elderly must depend upon:

    a. the patient's diagnosis
    b. financial considerations
    c. the patient's personal preference

Psychotropic Medications

1. b
2. c
3. c
4. b
5. a
6. c
7. a
8. c
9. b
10. a

BLANK PAGE

Exerpted from Community Mental Health by Bernard L. Bloom.

HISTORICAL ANTECEDENTS OF THE COMMUNITY MENTAL HEALTH MOVEMENT

Two separate historical traditions—one based in mental institutions and the other based in the community—came together shortly after World War II to provide early direction to the community mental health movement.

Throughout history, each major theory of psychopathology has been accompanied by at least one proposal for treatment. The oldest view of psychopathology—that psychiatric disorders arise from the supernatural and that psychiatric patients have been invaded by evil spirits and thus have become evil themselves—brought with it such "treatments" as trephining (cutting a section out of the skull to let the evil spirits escape), beating, burning, or other forms of punishment to drive out the spirits, and exorcism or prayer involving pleading with the spirits to leave the patient. Counteracting this early view, called *demonology*, were the views of Hippocrates and other Greek physicians of the pre-Christian era, who held that mental disorder is a disease process no different from any other disease process, that its origin is thus natural rather than supernatural, and that its treatment should therefore be in the hands of physicians rather than priests. Although the Hippocratic view was an advance over earlier views of the origin of psychopathology, treatments were not necessarily any more humane, and for a thousand years or more the treatments of choice for psychiatric disorders were often just as depletive in character as the treatments for other diseases—purging, bleeding, blistering, and giving drugs to make the patient vomit. The debate raged then, as it continues to do, over whether the psychiatric patient is sick or evil and whether psychopathology is fundamentally a disorder of the body or a disorder of the spirit.

In contrast to those who favored depletive, weakening treatments for diseases, both mental and physical, was a movement whose proponents advocated restorative or strengthening treatments such as bed rest, a cheerful environment, and good nutrition. This new outlook on psychiatric disorders was endorsed by both clergymen and physicians—by persons who believed psychiatric disorders were diseases of the spirit and by those who believed they were diseases of the body. Thus the notion of the *retreat*—a place where troubled persons could go to escape the psychological rigors of their world—was developed by the clergy, while the hospital came to serve the same function in the hands of physicians, particularly during the brief period that came to be known as the era of *moral treatment* (Bockoven, 1963; Dain, 1964).

Development of psychiatric hospitals

Until perhaps 100 years ago, patients who could afford the best medical care available were treated in their homes, while the poor were treated in hospitals, which were originally run by religious orders. This practice was true of psychiatric patients as well. The oldest mental hospital functioning today was started in Valencia, Spain, in 1409 (Andriola & Cata, 1969). The hospital staff held many of the values held by mental hospital workers today. Voluntary admissions were encouraged, and patients were discharged as soon as they were well enough to function in society. Efforts were made to protect as well as treat hospitalized patients and to avoid isolating them from their communities. Between the 15th and 19th centuries, many more hospitals were built in Europe, but the tradition begun in Spain of linking psychiatric hospitals to the community was interrupted.

During the first half of the 19th century, few facilities existed in the United States for the humane treatment of the mentally ill. Those that did exist were privately operated and tended to serve psychiatric patients who were able to pay. The vast majority of psychiatric patients, unable to afford private care, were "treated" in their home communities, together with the physically sick, the poor, the aged, the mentally retarded, and the neglected (see Deutsch, 1949). Some of these "patients" were cared for in their homes. In some communities they were auctioned off; in other communities a contract was made with a single person who, for a fixed fee, agreed to provide care. Finally, some were lodged in prisons or poorhouses, which were usually supported by the local community.

The state-hospital movement began as a protest against these scandalously poor community programs, and the name of Dorothea Dix is permanently identified with this movement (see, for example, Goshen, 1967, pp. 501–504). Going to teach Sunday school in a Massachusetts jail one Sunday in 1841, she was shocked at the conditions and at the fact that there were many obviously mentally disturbed patients among the inmates. She began a long crusade that led to the development of mental hospitals supported by state funds. Before her career ended, 32 state mental hospitals had been built in the United States, care of the mentally ill had been removed from the local community, and the professional orientation toward the insane had been changed from seeing them as no different from paupers or criminals to seeing them as sick people in need of hospital care.

During the early days of state mental hospitals, efforts were made to pattern their programs after the few privately operated psychiatric hospitals then in existence in the United States. In 1842 Charles Dickens visited what is now the Boston State Hospital and reported on his experiences.

> The State Hospital for the insane [is] admirably conducted on those enlightened principles of conciliation and kindness which twenty years ago would have been worse than heretical. . . . The patients . . . work, read, play at skittles, and other games; and when the weather does not admit of their taking exercises out of doors, pass the day together. . . . Every patient in this asylum sits down to dinner every day with a knife and fork; and in the midst of them sits [the superintendent]. . . . At every meal, moral influence alone restrains the more violent among them from cutting the throats of the rest; but the effect of that influence is reduced to an absolute certainty, and is found, even as a means of restraint, to say nothing of it as a means of cure, a hundred times more efficacious than all the strait-waistcoats, fetters, and handcuffs, that ignorance, prejudice, and cruelty have manufactured since the creation of the world. . . . In the labour department, every patient is as freely trusted with the tools of his trade as if he were a sane man. In the garden, and on the farm, they work with spades, rakes, and hoes. For amusement, they walk, run, fish, paint, read, and ride out to take the air in carriages provided for the purpose. They have among themselves a sewing society to make clothes for the poor, which holds meetings, passes resolutions, never comes to fisticuffs or bowie-knives as sane assemblies have been known to do elsewhere; and conducts all its proceedings with the greatest decorum. . . . They are cheerful, tranquil, and healthy. . . . Once a week they have a ball, in which the Doctor and his family, with all the nurses and attendants, take an active part. . . . Immense politeness and good-breeding are observed throughout. . . . one great feature of this system is the inculcation and encouragement, even among such unhappy persons, of a decent self-respect [1842, pp. 105–111].

Rise and fall of moral treatment

The private hospitals founded in the United States in the late 18th and early 19th centuries were influenced in large measure by European experiences that had shown that humane treatment was not only more satisfying to administer but more effective than the chains, purging, and bloodletting of earlier years. The most influential European was the French psychiatrist Philippe Pinel, superintendent of two Parisian psychiatric hospitals. Serving as what is now called a role model, he set an example of how patients should behave. He was inspired to do this by a mental hospital director who taught him about the curability of insanity. In 1806 Pinel wrote:

> Forgetting the empty honours of my titular distinction as a physician, I viewed the scene that was opened to me with the eyes of common sense and unprejudiced observation. I saw a great number of maniacs assembled together, and submitted to a regular system of discipline. Their disorders presented an endless variety of character: but their discordant movements were regulated . . . by the greatest possible skill, and even extravagance and disorder were marshalled into order

> and harmony. I then discovered, that insanity was curable in many instances, by mildness of treatment and attention to the state of the mind exclusively, and when coercion was indispensable, that it might be very effectually applied without corporal indignity. . . . I saw, with wonder, the resources of nature when left to herself, or skilfully assisted in her efforts. . . . Attention to these principles alone will, frequently, not only lay the foundation of, but complete a cure: while neglect of them may exasperate each succeeding paroxysm, till, at length, the disease becomes established, continued in its form, and incurable. The successful application of moral regimen exclusively, gives great weight to the supposition, that, in a majority of instances, there is no organic lesion of the brain [Pinel, 1962, pp. 5, 108–109; see also Joint Commission on Mental Illness and Health, 1961, pp. 28–32, and Ewalt & Ewalt, 1969].

In 1813 Samuel Tuke, the British physician who directed the York Retreat, founded by his grandfather some years earlier, described the rationale of moral treatment by noting that "most insane persons, have a considerable degree of self command; and . . . the employment and cultivation of this remaining power, is found to be attended with the most salutary effects" (Goshen, 1967, p. 494). Writing in 1866, Seguin noted that

> long before physicians had conceived the plan of correcting the false ideas and feelings of a lunatic by purgatives, or the cranial depressions of an idiot by bleeding, Spain had produced several generations of monks who treated with the greatest success all kinds of mental diseases without drugs, by moral training alone. Certain regular labors, the performance of simple and assiduous duties, an enlightened and sovereign volition, watching constantly over the patients, such were the only remedies employed [Goshen, 1967, pp. 165–166].

Reform in the care of the mentally ill, which started a century ago, was part of a larger movement in the United States whose objectives included prison reform, abolition of slavery, and women's suffrage and which reflected a growing optimism—a belief in human perfectibility rather than predestination.

Unfortunately, a series of events resulted in the virtual destruction of the moral-treatment movement during the next several decades. By the late 19th century, state mental hospitals had grown in size and number, but the quality of the treatment had so deteriorated that they were hardly better than the community programs they had been built to replace. Too little money was allocated by states for the care of the mentally ill in the new state hospitals, and not enough training programs existed to produce the number of skilled employees needed, even where money was available to hire them. In addition, a growing antagonism toward foreign-born people was developing as a consequence of the waves of immigration into the United States, and both the poor and the mentally disordered were heavily overrepresented among the foreign-born. At Worcester State Hospital in Massachusetts, the proportion of foreign-born among all admissions climbed from 10% in 1844 to 47% in 1863. Nearly half of all first admissions into Worcester State Hospital between 1893 and 1933 were foreign-born, and most of these foreign-born patients were destitute (Bockoven, 1963, p. 24). Thus, hospitals for the mentally ill became overcrowded with people for whom many Americans had little sympathy, and adequate treatment became an impossibility. At Worcester State Hospital, for example, between the 1830s and the 1870s, the average daily population was about 400, and the average length of hospitalization was about one year. By 1950 there were 2500 patients in the hospital, and the average length of hospitalization had increased to nearly five years (Bockoven, 1963, p. 23; see also Grob, 1966).

Meanwhile, the profession of psychiatry was developing as a specialty of medicine, and humane, "moral" treatment could hardly be thought of as medical in character. For psychiatrists to develop and maintain some respectability among their medical colleagues, they had to find organic causes and organic treatments. As medical schools became the loci of medical training, the psychiatrists who were interested in moral treatment found no one to replace themselves.

As a consequence of all these events, state psychiatric hospitals were not able to deliver on their promises. Recovery rates decreased and hospitals gradually filled up with chronic, virtually untreatable patients. What had started as an era of optimism regressed to belief in the notions of heredity, predisposition, organic pathology, and incurability.

The deterioration of state mental hospitals continued until after World War II. A few hospitals were unusually well staffed, but on the whole, hospitals functioned with appropriations averaging two or three dollars per patient per day. Staffs were overworked, frequently untrained, and ill paid, and little that could reasonably be called "treatment" took place. Between 1845 and 1945, the United States saw the establishment of almost 300 state mental hospitals, nearly all of which—after an initial flurry of enthusiasm and hope—quickly lapsed into vast storehouses for some of the most disabled and miserable people in the country. By 1955, on an average day, nearly 600,000 persons occupied beds in mental hospitals supported by state or county funds. Both the importance and the plight of state mental hospitals can be seen in the following figures. Of the 1,241,000 people who were patients at any time in psychiatric hospitals in the United States in 1957, including public, private, and Veterans Administration hospitals, nearly 840,000 (approximately two-thirds) were in state mental institutions. In 1960, while general medical hospitals had a daily patient cost of more than $27 and private psychiatric hospitals and psychiatric units in general hospitals expended about $17 per patient per day, daily costs in state mental institutions averaged less than $4.50 per patient. By 1976 the average daily expenditures per patient in state mental institutions had increased to $43.55 (Witkin, 1979), but general-hospital expenses per patient per day averaged $173.68 (U.S. Department of Health, Education and Welfare, 1978b). In 1971 court action had to be brought against one state before it provided proper treatment to the patients in its state hospital. The Department of Justice, in this suit, noted that placement in this state mental hospital "means not only the absence of treatment but indeed is probably anti-therapeutic and harmful to those unfortunate victims. . . . Treatment is still an elusive concept and is far from reality . . . and has retrogressed since the 19th century when the institution was founded. It simply does not exist for those who are unfortunate enough to be old, mentally ill, or unwanted . . . and placed by the State in its human warehouse" ("Federal Court Upholds Right to Treatment," 1972, p. 1).

Alarm at the growing failure of psychiatric institutions to provide effective care was not only based on humanitarian grounds. New symptoms that developed after hospital admission began to appear in patients with increasing frequency—symptoms that were thought to be brought about by the deficiencies in psychiatric care just described. These symptoms, grouped together under the term *social breakdown syndrome* (American Public Health Association, 1962; Gruenberg, 1980), included severe withdrawal, loss of interest in social functioning and in personal appearance, anger, assaultiveness, and personal dilapidation. The social breakdown syndrome was thought to be socially determined, a consequence of hospitalization almost regardless of initial diagnosis, and responsible for the growing chronic character of psychopathology. Because the social breakdown syndrome was thought to be the result of deficiencies in psychiatric care, changes in the organization of that care would be required before the syndrome could be controlled.

Changes in institutional psychiatric care

In the most forward-looking state mental hospitals, starting in about 1950, three developments took place that set the stage for a major shift in the orientation of mental health professionals toward institutional psychiatric care. First, the field of psychopharmacology began its current period of rapid growth with the development of new tranquilizing drugs. These drugs reduced anxiety, discomfort, and bizarre behavior in many patients, thus speeding discharge from psychiatric hospitals. Because these drugs modified the emotional components of psychiatric disorders without impairing intellectual capacities, they were far superior to the sedating drugs that had been in use until that time. Not only was recovery accelerated, but many patients were able to function in the community by continuing use of these drugs at home (see Cole & Gerard, 1959; Kolb, 1968b, pp. 574ff.; Pasamanick, Scarpitti, & Dinitz, 1967).

The second factor was the development of the philosophy of the *therapeutic community*. This orientation to psychiatric treatment grew out of the axiom that therapeutic potential resides in patients as well as staff. According to this philosophy, a democratic community composed of patients and staff working together could take advantage of this therapeutic potential and thereby increase the effectiveness of psychological treatment. The name of Maxwell Jones is most prominently associated with this movement, which began in England and Scotland under his leadership and spread rapidly to many U.S.

psychiatric hospitals (Jones, 1968). When psychiatric inpatient wards were converted into therapeutic communities, patients and staff began to share responsibility for assessing patient behavior and making recommendations for treatment planning. Patients had to justify their requests for discharge or for changes in treatment status not only to the professional staff but to their fellow patients, and with this orientation to treatment, clinical improvement appeared to be faster and longer-lasting.

The third development was geographic decentralization in large state mental hospitals; patients were placed in wards according to their place of residence before hospitalization. What started out simply as an administrative reorganization rapidly developed into the vehicle for the establishment of working relationships between the hospitals and the communities they served. Before geographic decentralization, state mental hospitals were just as functionally isolated from their communities as they were geographically isolated.

You can best appreciate the significance of geographic decentralization if you understand what it replaced. As state mental hospitals increased in size, the general pattern of administrative organization came to involve an admitting service for newly arriving patients, several acute treatment services to which most patients were transferred after initial diagnostic studies had been completed, and several chronic treatment services to which patients who had not recovered sufficiently to be discharged were transferred. Both acute and chronic treatment services were frequently organized around treatment modalities, so that there were electrical shock treatment wards, insulin treatment wards, wards for patients who had special dietary restrictions or certain physical diseases, wards for elderly patients, wards for alcoholics, and so on. The most highly trained staff members as well as the greatest number of staff members tended to work in admission and acute treatment services, while on chronic wards there were fewer personnel, particularly fewer well-trained personnel, as well as fewer amenities. An aura of hopelessness pervaded these chronic "back wards"; neither patients nor staff aspired to very much in the way of therapeutic progress, and these wards became custodial in the worst sense of the term. In most state mental hospitals, a majority of patients were lodged in these chronic treatment wards. That is, few patients recovered quickly after admission and were discharged; many were transferred to chronic treatment wards, where they remained for years, often for decades, or even for life.

The concept of geographic decentralization, or regionalization, was an attempt to break out of this administrative pattern. Patients of all degrees and types of psychopathology began to be housed according to their home communities, so that on one ward might be placed all patients from a particular city. Admission services were abolished. Newly admitted patients were sent directly to their geographic units. Hospital staff was equitably distributed across geographic units. The only exceptions to geographic decentralization were made for those patients who required such specialized services that it would be impossible to duplicate them in each geographic unit. Thus, most geographically decentralized hospitals maintained a centralized medical facility for the treatment of patients with physical diseases, and most decentralized hospitals were required to maintain separate facilities for those convicted of criminal acts. Many decentralized hospitals continued to have special treatment facilities for psychiatrically disturbed children. But in all hospitals that underwent geographic decentralization, the vast majority of patients lived in wards with their neighbors, as it were. The strong could help the weak. The community had a particular section of the hospital with which it could identify. Hospital personnel had a rationale for spending part of their time in the community from which their patients came, first in providing aftercare services and later in providing alternatives to hospitalization in collaboration with community-based agencies. And finally, decision making was decentralized; decisions about patient care came to be made at ward level rather than at higher administrative levels.

These three developments—tranquilizing drugs, the therapeutic community, and geographic decentralization—worked together to democratize the clinical decision-making process, establish closer working relationships between the hospital and the community, and lower the hospital census. The price paid for these developments, however, was a growing tendency for mental health professionals to see all psychiatric hospitalizations as undesirable. The National Institute of Mental Health funded studies to examine how hospitalization could be prevented (see Pasamanick et al., 1967, for example). State hospitals were envisioned as being converted into community mental health centers (Levy, 1965) or vocational training schools (Stewart, Lafave, Grunberg, & Herjanic, 1968). If they were to remain open to receive psychiatric patients, it was thought, they would have to be much smaller and would need to become far more integrated into the community they served than was typical (Baker, Schulberg, & O'Brien, 1969; Ozarin & Levinson, 1969).

A few authors cautioned against excessively rapid abandonment of the psychiatric hospital. Mendel (1967) noted that hospitalization may be the treatment of choice for (1) persons who are so disturbed that they cannot maintain useful relationships with therapists as outpatients, (2) persons whose impulse control is so poor that they frighten those members of their families who must care for them, (3) individuals whose psychopathology has alienated them from family and friends, who now refuse to care for them, (4) persons who are malnourished or who make excessive use of drugs, (5) persons who need to be protected against self-destructive impulses, (6) persons from whom regularly available supportive resources in the community need a brief vacation, and (7) individuals who must be removed from a pathological environment. The Committee on Therapeutic Care of the Group for the Advancement of Psychiatry, in its report *Crisis in Psychiatric Hospitalization* (Group for the Advancement of Psychiatry, 1969), emphasized the vital role of the psychiatric hospital as one point on a comprehensive continuum of psychiatric treatment and provided its own list of indications for hospitalization. More recently, Gruenberg (1974) and Rabiner and Lurie (1974) have also outlined what they believe to be the circumstances under which hospitalization may be the treatment of choice.

Thus, the complex developments that were dramatically changing the public psychiatric hospital were at the same time generating debate over how best to utilize the mental institution in a system of mental health services. Meanwhile, changes were taking place in attitudes toward community-based care.

Bloom, Bernard L. (1977). Community Mental Health: A General Introduction. Monterey, California. Brooks/Cole Publications.

BLANK PAGE

It is important that the instructor keep in mind the purpose of the assessment process. Assessment of the older client is the collection of information about the person with a purpose. The goal is to gain an understanding of the client's needs and of his or her capabilities. Only by looking at the client from several perspectives can we, as social service professionals, begin to plan correct interventions. These interventions should assist our client in achieving and maintaining the highest level of independent functioning that is possible for them.

The most effective assessment process will gather information about a client from psychological, physiological, and social aspects--in other words a multi-disciplinary approach. Keep in mind that rarely does an older client have a single isolated problem. More often than not the client will present one gross problem that in turn causes complications in multiple areas of their lives. Conversely, the client may not appear to have any single major problem. Only after a thorough investigation into all aspects of their life may we discover some areas where we can offer assistance.

Remind students that we do assessments of others all of the time. The assessments that we make about those around us are colored by personal experiences, prejudice, and stereotypes. This is unavoidable. We can reduce the effects of stereotyping and personal bias by using formal assessment instruments when evaluating the needs of our clients.

Reliability refers to the ability of an instrument, over time, to produce the same results. The reliability of an instrument is studied in three ways: by repetition (test-retest), by using two parts of the test which have the same kind of items (split half), or by studying the consistency of performance across items.

Validity looks at whether a test measures what it is supposed to measure. Validity is the property of a test that makes the information obtained from it useful. A test or procedure is never valid in general; it can only be valid for something. If a test is valid, it will produce dependable information about the topic that interests the investigator.

Three types of validity are considered: content, construct, and predictive. Content validity answers the question of whether or not the content of the test constitutes an adequate sample of the subject matter. Construct validity focuses on the extent to which a measure performs in accordance with theoretical expectations. Predictive validity is sometimes referred to as criterion-related validity. It has the closest relationship to what is commonly meant by validity. Predictive validity has an intuitive meaning that is not shared by other types of validity. For example, college entrance exams have predictive validity because high scorers usually do well in their studies at college. In other words, what we are seeing is a correlation between a test score and task performance.

Discuss the types of assessment procedures used: survey instruments, hospital records, structured and informal interviews. Discuss the pros and cons of each in relationship to what constraints are on your students and what they are trying to accomplish.

Discuss normalcy with students. How do we establish norms?

References

Carmines, E.G., & Zeller, R.A. (1979). Reliability and Validity Assessment. Sage University Paper Series on Quantitative Applications in the Social Sciences, 07-001. Beverly Hills and London: Sage Publications.

Sundberg, N.D. (1977). Assessment of Persons. The Prentice-Hall Series in Personality. New Jersey: Prentice-Hall, Inc.

BLANK PAGE

ASSESSMENT: METHODS AND PROCESS

Name: ______________________ **Date:** ______________

CIRCLE THE CORRECT ANSWER.

1. Assessment can best be defined as a means to:

    a. label the client
    b. gain understanding of the client
    c. provide information to eliminate clients from community programs

2. One of the main reasons for careful assessment is to prevent __________, which causes the substitution of subjective opinions for objective data.

    a. reassessment
    b. unnecessary costs
    c. labeling

3. Which of the following is not discussed as a rationale for assessment?

    a. to reduce the number of institutionalized elderly
    b. to manage resources and establish intervention priorities
    c. to evaluate efficacy and efficiency of treatment

4. Reliability in assessment refers to:

    a. the consistency of a measure
    b. meaning
    c. social value

5. Validity in assessment refers to:

    a. the stability of a measure across time
    b. the true value or meaning of a measure
    c. the feasibility or cost of using a measure

6. The main criticism of data gathered from existing records is that they:

    a. are expensive to collect
    b. are not usually readily available
    c. are often unreliable, and therefore not valid

7. To insure that interview data is reliable and valid, it is important:

    a. that the interview be short and to the point
    b. that the interviewer is skilled, prepared, and can establish rapport
    c. that the unstructured technique be used

8. Of the four basic methods discussed, which probably has the best reliability and validity?

   a. records review
   b. instrument and test administration
   c. direct observation and measurement

9. One of the disadvantages of using direct observation and measurement is that:

   a. many important factors, such as cognitions and affections, cannot be observed
   b. behavior seldom changes
   c. observers do not know what to look for

10. A common flaw which many of the tests used for assessment in the elderly share is:

    a. the test is too difficult for the elderly due to visual impairment
    b. the test is constructed for and validated with younger population groups
    c. the test is biased for minorities

Assessment: Methods and Process

1. b
2. c
3. a
4. a
5. b
6. c
7. b
8. c
9. a
10. b

BEST COPY AVAILABLE

BLANK PAGE

Lack of self care skills is a major problem for many elderly clients. It is a major reason for institutionalization. It is important that students keep in mind that the more rapidly the ADL skills of a client are assessed the more rapidly interventions can be started. Good ADL skills foster self-esteem, independence and an improved social life for the older person. In addition, the older person who is capable of caring for themselves to some extent will maintain an informal support system for a longer period of time.

Some possible topics for discussion among students are learned helplessness and caregiver stress. Learned helplessness can result when we insist on doing everything for someone who is experiencing some impairment. Caregiver stress can result in family turmoil and early or unnecessary institutionalization.

Discuss the assessment methods described in the text. Discuss the practicalities of the "show me " method.

Review the text on Social Skills. Discuss with students how any of the skills training techniques might be adapted to their clients. How do the students think that they can help their older clients rebuild a social support system.

This section discusses the techniques of mental health assessment. Encourage the students to read the text before the class meets.

The author reviews both objective and subjective methods of assessment and explains the theory behind each. The points for and against several individual assessment instruments are given. Review these with the class. Emphasize the differences between objective and subjective testing methods.

A possible point for class discussion might be which method is potentially less susceptible to bias on the part of the interviewer. Remind the class, again, that interviewer bias is very difficult to avoid. We all have our likes and our dislikes. Bias, or prejudice if you will, is not always a negative factor. An interviewer can be biased towards a client just as easily as he or she can be biased against them. Any of us can feel so much sympathy toward a potential client that we really want them to qualify for our services.

Another good topic for discussion is what the group thinks of assessment and testing in general, as it relates to their particular job and as it relates to the goal of their agency. Does the testing and assessment process help them better serve the population that they are supposed to be serving? Or, does it act as a barrier to service?

Review with students the four basic assessment concepts of working with older clients. These are:

1) an illness is not caused by old age, but by a definite disease,
2) all people must be considered in relation to their environment,
3) keep multiple pathology in mind, and
4) always remember that the normal aging process may alter the manner in which a disease presents itself in an older person; symptoms may be suppressed or masked.

Emphasize during your lecture that we must always strive to obtain as clear a picture as possible of what was or is normal behavior for the older client. Only in this way can we accurately assess current behavior.

In the materials for the instructor, you have a copy of the Social Readjustment Rating Scale. You might want to copy this and give one copy to each of your students. Have them review their own lives. Tell them to think of the past twelve months, check off the items that have happened to them and then total their scores. Past studies have shown that there is a definite relationship between the amount of change in a person's life and the risk of illness. People whose Life Change Units (LCU) total between 150-199 have a 37% chance of becoming ill within two years. The chance is 51% if the score is between 200-299 and with greater than 300 LCUs, there is an 80% chance of becoming ill.

Keep in mind that some of these items are more likely to occur in the life of an older person, within a relatively brief period of time. Discuss the domino effect that a major life event can trigger. The death of a spouse is not an unexpected event in the life of an older person. Ask students to list other changes that might be caused by the death of one's spouse.

Emphasize the importance of examining all aspects of a person's life when attempting a functional assessment. Social, psychological and physiological components must all be taken into consideration. Review the reasons given in the text for using the multi-dimensional approach.

In the handouts provided to you is a table that presents the characteristics, contents, reliability, and validity of various assessment instruments. Review these with the class.

References

O'Hara-Denereaux, M., Andrus, L., & Scott, C. (1981). Eldercare: A Practical Guide to Clinical Geriatrics. New York: Greene & Stratton, Inc.

MAJOR ASSESSMENT AREAS: ADL, SOCIAL SKILLS, MENTAL HEALTH STATUS, AND PHYSICAL HEALTH AND FUNCTION

Name: ____________________________ **Date:** ________________

CIRCLE THE CORRECT ANSWER.

1. A major problem confronting society in regard to the elderly is:

    a. a lack of acute care facilities (hospitals)
    b. an unwillingness of elders to cooperate with professionals
    c. an inability of elderly persons to perform ADL and to function adequately socially

2. Depression and hypochondriasis are common among the elderly and have been linked to:

    a. visual impairment
    b. social skills deficits
    c. mobility problems

3. When assessing an elderly person, the most effective approach to use is:

    a. multidisciplinary
    b. medical
    c. environmental

4. Which of the following is not one of the basic concepts of assessment to keep in mind when working with elderly clients?

    a. The client is ill because he/she is old.
    b. Every individual must be considered in relation to his/her environment.
    c. The process of aging may complicate diseases of later life.

5. An example of an objective assessment instrument is:

    a. the Rorschach
    b. the MMPI
    c. TAT (Thematic Apperception Test)

6. The most effective assessment process will include information gathered from the following:

    a. social background only
    b. physical history only
    c. physiological, psychological, and social aspects of the client

7. The ____________ method of test construction involves using items that differentiate between two or more different groups.

    a. judgmental
    b. group-contrast
    c. internal consistency

8. Projective techniques are based on the premise that:

   a. defenses must be loosened in order for significant aspects of the personality to be revealed
   b. no interpretation of data should be required
   c. self-reports are always valid

9. A common complication of depressive disorders in the elderly is:

   a. respiratory problems
   b. paranoia
   c. nutritional deficit

10. Research suggests that many aches and pains commonly associated with older age result from:

   a. poor nutrition and lack of physical fitness
   b. just getting older
   c. hypochondriasis

Major Assessment Areas: ADL, Social Skills, Mental Health Status, and Physical Health and Function

1. c
2. b
3. a
4. a
5. b
6. c
7. b
8. a
9. c
10. a

BLANK PAGE

In: Lewinsohn, P. & Teri, L. (Eds.)
Clinical Geropsychology New York:
Pergamon, 1983.

Chapter 4

Social and Daily Living Skills

Roger L. Patterson and David A. Eberly

DESCRIPTION OF PROBLEM

Daily living and social skills are critical for the elderly. Much evidence is available today to indicate that the inability of elderly persons to care for themselves (usually referred to as activities of daily living or ADL) or to function adequately socially is a major problem facing our society. Such deficits, when severe, may result in institutionalization or custodial care by families. Less extreme deficits may also result in isolation and loss of independence. The Health Care Financing Administration (1981) has reported that lack of self-care is the major cause of institutionalization of the elderly. In addition, such deficiencies of self-care skills are recognized among nursing home residents (e.g., Pfeiffer, Johnson, & Chiofolo, 1980) and the loss of adequate social relationships contributes to institutionalization (Lowenthal, 1964). For example, in an early review of studies concerning problems encountered by the elderly, Birren et al. (1963) concluded that:

> As the environment showed qualities of deprivation or displacement of the person (in loss of intimate persons, loss of income, in cultural displacement) the attitudes and behavior of the aged showed more deteriorative qualities. Psychological reactions to the loss of friends and other environmental supports may amplify if not initiate changes in the older nervous system and thereby the rest of the organism. (p. 314.)

More recently, Atchley (1977) stated that breakdown of the social support system was the "primary cause of institutionalization of the elderly" (p. 116).

We hypothesize that the issues of self-care and social supports are strongly interactive in several ways. Most obviously, persons who are not taking good care of themselves and their affairs can survive longer and better in the community if there are others available to care for them. Whether or not

BEST COPY AVAILABLE

others are available may depend on the social skills of the elderly person. Some people may require very little assistance to maintain themselves in the community, but they may lack the ability to relate to others in such a way that even minimal assistance will be provided. Others may require a great deal of assistance but they possess enough desirable social qualities that their needs are readily met. In addition, from behavioral psychology it can be postulated that older people will be more likely to continue adequate self-care and social functions, despite various adversities, to the extent that they have regular and strong relationships with others reinforcing, and thus maintaining, adequate social and self-care behavior. Put simply, if there is no one significant person or persons to care about us, we may stop caring for ourselves. In addition to self-care, desirable emotional states in humans may require an adequate level of social relations.

The other side of this interaction between social supports and self-care is that people become less socially desirable if they fail to practice good hygiene and fail to maintain their residence adequately. One may conceive of a spiral of reciprocal losses of self-care and losses of social supports eventually leading to the need for institutional care. Where the spiral begins may not be as important as the fact that it is occurring.

There are important reasons, both humanitarian and economic, why such issues are of particular concern at this point in history. The economic reason is the huge cost of dealing with the problems of the elderly by institutionalizing them. According to the Health Care Financing Administration's report for the year 1979, 117.8 billion dollars were spent on nursing home care for the elderly: 49 percent of this was paid for by the U.S. government. This cost is expected to grow rapidly because of the projected growth of the elderly population. The number of persons aged 65 and older is expected to double by the year 2030 while the general population increases by only 40 percent. Most importantly, those who need the most care (i.e., those aged 85 and older) are expected to triple in number.

There is also an enormous human cost involved in the loss of a normal existence by large numbers of people. Atchley (1977) reported that the older person fears being placed in a nursing home and that such placement is associated with the loss of independence and rejection by the family. It is also likely that many families feel guilt over institutionalizing a family member.

Prevalence of Self-Care and Social-Skills Problems

There is no question but that the prevalence of social and self-care deficits in the institutionalized elderly is very high. In addition, research data exist that pertain directly to the prevalence of those deficits in community resident elders. One of the best estimates of the prevalence of overall self-care deficits comes from a needs-assessment study of 997 residents of Durham County, North Carolina, aged 65 and over (Blazer & Maddox, 1982). These authors used the Multidimensional Functional Assessment Questionnaire (MFAQ) developed by the Duke University Center for the Study of Aging and Human Development (1978) to assess function in the areas of social resources, economic resources, mental health, physical health, and self-care (ADL). Twenty-two percent of this sample showed impairment on ADL. Furthermore, ADL scores were strongly associated with mental-health impairment ($r = .61$). Significantly, the authors concluded that these data from North Carolina are similar to results of a previous study in Cleveland, Ohio.

Cairl (in press) has recently assembled data revealing the incidence of ADL problems in the elderly population (age 65+) in the Tampa Bay region of Florida, a favorite retirement area for the United States. Specially constructed interviews, administered to a scientifically constructed sample, showed that 17.4 percent of this group had problems with one or more basic ADL skills (such as bathing, eating, and toileting), and 13.4 percent had problems with more complex daily living skills (such as cooking, shopping, and transportation).

From these two studies it may be easily concluded that ADL impairment is highly prevalent among people age 65 and older. Furthermore, these ADL deficits are experienced by elderly in the community and not just by those who are institutionalized.

It is difficult, if not impossible, to estimate accurately the prevalence of social-skills deficits among the elderly because previous studies have not directly measured social skills. However, the prevalence of social-skills deficits can be inferred from studies focused on conditions that are known to include social-skills problems. For example, depression and hypochondriasis are common among the elderly (Butler & Lewis, 1977; Zarit, 1980) and have been linked to social-skills deficits (Larson, 1978; Libet & Lewinsohn, 1973; Maddox, 1964). Thus, the high prevalence of depression or hypochondriasis among the elderly may be related to high prevalence of social-skills deficits.

The present authors and their colleagues (Eberly, Patterson, Jackson, & O'Sullivan, 1981) conducted a survey of geriatric patients at a state mental hospital. This survey, which included a behavioral assessment, indicated that 76 percent of the patients could not function effectively as members of a group or participate in group activities, and that 66 percent could not initiate social contacts. A survey of all geriatric patients in state mental hospitals conducted by the Florida Department of Health and Rehabilitative Services, Alcohol, Drug Abuse, and Mental Health staff (1981) found that 65 percent could not function as group members; 66 percent could not initiate social contacts; and 42 percent could not respond to overtures.

Social-skills deficits of the elderly may also contribute to numerous problems in living not directly associated with the usual categories of pathology. Thus, Corby (1975) suggests that social-skills deficits are often involved with the elderly person's passivity, problematic and contradictory communication with relatives, and social isolation.

Rationale for the Aging Program of the Florida Mental Health Institute

The basic rationale behind the Aging Program of the Florida Mental Health Institute (FMHI)[2] in Tampa (hereinafter called the Program) was that, in view of the above, it seemed reasonable that improving the social and self-care skills of elderly people might have great humanitarian and economic benefits for society in general and for the affected elderly and their families in particular.

The Program originated from the State Mental Health Agency's concern with the fact that many old people who might benefit from other treatment were being referred to state hospitals primarily for medical and custodial care. The Program sought to develop and to evaluate alternative treatments for two groups of elderly: (1) those already residing in state mental hospitals and local psychiatric wards for whom the realistic goal was to return to noninstitutional community placements; and (2) those currently residing in the local community but who seemed to be in danger of institutionalization without intervention. Thus, the overall purpose of the Program was to promote and maintain community living.

Obviously, there were some conditions and behaviors that required special care and precluded community living as an immediate goal. Criteria were developed to exclude these conditions. To be included in the program, clients had to be: age 55 or older; not in need of acute medical or skilled nursing care; minimally ambulatory by some means; and continent and able to live safely in an unlocked environment without strict supervision. Persons who failed to meet these criteria were felt to require institutional care for medical treatment and safety. There were no diagnostic or financial criteria for admission to the Program.

Other factors also governed the nature of the Program. Given the way the population was defined, treatment approaches that were to be developed had to be effective with a great variety of problems that would have an equally great heterogeneity of etiologies. The Program would also have to be applied by a diversity of personnel, many of whom would not be professionals or very well educated: most of the people who work with the elderly in the state are nonprofessionals, with little formal education.

These factors represent widespread reality: masses of elderly in need of this type of help come from many backgrounds and have a great variety of medical conditions. Doctors, nurses, social workers, and psychologists are not sufficiently available to work directly with the elderly who need their services. Nor are they able to spend the time needed to rehabilitate social and self-care skills deficits.

A review of the relevant literature (Bates, 1975) indicated that a highly structured training environment combined with the availability of medical treatment and good social-work services was a desirable way to approach overcoming social and self-care deficits. Furthermore, behavioral psychology was considered to provide a good general framework for the development of such a structured environment. Although there had been several previous demonstrations of the usefulness of the behavioral model and its concomitant techniques to the problems of the elderly (see Patterson & Jackson, 1980, for a recent review), there were no available comprehensive treatment programs for use with this particular group of elderly based upon the behavioral model. Most of the work with the elderly has been dominated by concepts and by interventions generated by what may be termed the medical and social models.

Both the medical and the social models offer a number of explanations as to why people with advanced age may cease to perform competently within the areas of ADL and social functioning. Probably each is somewhat correct at least some of the time for some of the people. The behavioral model offers many advantages not fully exploited so far in work with the aged. The medical model leads one to look at physiological changes, many of which are not currently reversible. The social model focuses on broad social changes affecting thousands or millions of people which may require many years and heroic interventions. The behavioral approach identifies observable behaviors and interventions that are readily applicable in the present and immediate environment, which will produce relatively quick changes if they are successful.

It is this immediate applicability, with the promise of fast results, that makes the application of behavioral concepts and methods highly desirable. The basic idea underlying our program was that if people displayed problem behaviors or skills deficits that could be defined in observable terms, then structured-learning situations could be created to overcome these problems, if not completely, then at least to some measurable degree.

Overview of the Modular Behavioral Treatment Program

Based upon the above rationale, it was decided that an appropriate approach would be to employ the behavioral model in the form of highly structured treatment components or behavioral modules. Six modules were developed: three taught activities of daily living, and three taught social skills. The three ADL modules taught self-care behaviors that were generally related to three types of placements. ADL I taught those basic self-care and eating behaviors needed for any noncustodial setting. Persons completing ADL I but no higher lever of self-care skills could be placed with families or in foster or boarding homes, which would provide for all other aspects of self-care. ADL II training stressed care of clothing and room, handling small amounts of money, and using the telephone. Persons completing ADL I and II would be prepared for life in the usual boarding home, in most foster homes, and in families, all of whom would be able to provide some assistance with additional needs. ADL III taught skills such as budgeting, meal planning and preparation, and obtaining community resources; it prepared people for independent living.

The social-skills series consisted of three modules and an optional social problem-solving training procedure. Conversation Training taught people to interact socially in a casual way. Communication Training taught people to express basic affects (such as expressing pleasure to someone about something they liked and displeasure about something they disliked). Self-Esteem Training taught people to recognize their own positive characteristics. Interpersonal problem solving was used with those individuals who had specific problems with particular people at this time in their lives; these individuals were taught the specific social behaviors needed to solve these particular problems.

The remainder of this chapter consists of three sections describing the assessments, interventions, and evaluation as used with the modules. The problems dealt with by the modules are very diverse and not specific to diagnostic categories or to particular isolated problems. While, of necessity, the modules are described individually, they should be seen as part of a total program.

ASSESSMENTS

Four major reasons for assessing ADL and social skills of the elderly in treatment settings may be identified: (1) to assess the degree of congruence between the functioning of the person with the requirements of a particular environment; (2) to determine the need for particular types of services in communities or institutions (needs assessment); (3) to prescribe interventions to be used to improve the level of functioning; and (4) to measure change in functioning over time.

With few exceptions, devices for assessing the elderly have been developed to determine readiness for institutional or for community placement, or to determine needs assessment. (See reviews by Bernal, Brannon, Belar, & Cameron, 1977; Curran & Wessberg, 1981; Linn, 1979; Smith, 1979.) Most of the scales used to assess the elderly came out of a psychometric tradition that sought to identify relatively permanent and stable characteristics of individuals. These scales were not concerned with the other two issues listed above: to prescribe interventions and to measure change over time. (Perhaps it is a further indictment of our attitudes toward the elderly that this is the case.)

The Program was interested in assessments that could be used to measure need for intervention and to measure changes occurring as a result of these interventions (Patterson, Penner, Eberly, & Harrell, in press). Two basic classes of instruments were used: (1) behavior rating scales and self-report measures that are general-purpose instruments and have been previously used in other research; and (2) assessments to measure acquisition of the skills taught in the modules.

General-Purpose Instruments

The general-purpose instruments were used to provide indications of relatively global behavioral change. In addition, these instruments could also be used to provide evidence of generalization of modular training since they measured social and ADL skills occurring in places and times other than within any particular intervention procedure.

Two types of behavioral rating scales have been found useful in the Program:

1. *The Nurse's Observation Scale for Inpatient Evaluation* (NOSIE-30: Honigfeld, Gillis, & Klett, 1966) is a general-purpose, psychiatric behavioral rating scale used for assessing clients in a ward setting. The 30 items on the NOSIE-30 are brief statements describing activities. Clients respond to each item by checking one of five responses indicating the frequency ("never" to "always") of the observed behavior during the most recent three-day period. Examples of items are: "Is sloppy," "Gets angry or annoyed easily," and, "Is messy in his eating habits." Seven different scores are obtained from this instrument. Six of these scores refer to mathematically derived factors. Three of the scores represent "positive factors": Social Competence (COM); Social Interest (INT); and Personal Neatness (NEA). The three negative factors are: Irritability (IRR); Manifest Psychosis (PSY); and Retardation (physical, not intellectual) (REA). The seventh score, Total Assets, is computed from the six factor scores with the use of a mathematical formula. Validity and reliability of the NOSIE-30 has been repeatedly established (Honigfeld et al., 1966; Smith, 1979). Designed to measure change over relatively short periods of time, the population used in the original development of the NOSIE-30 scale was elderly.

2. *The Community Adjustment Potential scale (CAP) portion of the Discharge Readiness Inventory (DRI)* (Hogarty & Ulrich, 1972) was developed to predict discharge readiness and the subsequent community adjustment of hospitalized schizophrenics (Hogarty & Ulrich, 1972). Significantly, the CAP has also been used in a day-care program (Michaux, 1971). The items for the DRI were originally developed by experienced social workers who had been asked to identify the critical components for discharge readiness. The items include social behaviors such as appropriate judgment, affect, and the ability to converse coherently. The 16 items of the CAP are scored in two sets, A and B. Set A (10 items) asks the rater to make judgments based on the client's behavior "during the last week or two" and to provide ratings on a 5-point frequency scale ranging from "never" to "always." Sample items are: "Wants to leave hospital" and "Engages in simple conversations about concrete subjects." Set B (six items) asks the rater, "If the client were to be discharged today, what would be your prognostic judgment about his or her behavior in the community?" Sample items are: "Could get along with his neighbors in his community placement" and "Could move about independently in the community." DRI items generally involve more advanced social and ADL skills than items found in most other scales.

The self-report measures used by the Program were as follows:

1. *Life satisfaction.* Life satisfaction, or subjective well-being, is a subject about which much has been written in the gerontological literature (Larson, 1978). Although several measures of life satisfaction have been created, Larson has noted that all of them measure primarily the same thing, as evidenced by the fact that the correlation between the various scales is high.

The Life Satisfaction Index (LSI) (Neugarten, Havighurst, & Tobin, 1961) was chosen for inclusion because of the great amount of research in which it has been used. It consists of 16 items to which the subject is asked to respond dichotomously (agree or disagree). Sample items are: "As I grow older, things seem better than I thought they would be," and "These are the best years of my life." The original basis for the inclusion of the items was the theoretical assumption that there are five major components of well-being in the elderly: zest rather than apathy; resolution and fortitude; congruence between desired and achieved goals; positive self-concept; and mood tone (Neugarten et al., 1961). The importance given to this type of measure in the gerontological literature would seem to make it highly desirable to include in many clinical and research efforts.

2. *Self-esteem.* Concern with loss of self-esteem by the elderly seems to be very widespread in the literature. The concept of lowered self-esteem is a basic in the theory of Kuypers and Bengston (1973) and in other sociological theories concerned with losses of social functioning in the elderly. The present

author and his colleagues (O'Sullivan, Eberly, Patterson, & Penner, 1979) have used the Self-Esteem scale (RSE) developed by Rosenberg (1965), which has also been used with the elderly by other investigators (Linn, 1979). The RSE is a 10-item Gutman scale created originally for use with adolescents. Examples of items are: "On the whole I am satisfied with myself," and "I certainly feel useless at times." There are four possible responses to each item, ranging from "strongly agree" to "strongly disagree." The scale has high test-retest reliability and has been found to have good convergent, discriminant, and concurrent validity (Rosenberg, 1979). The items themselves appear to have good face validity and are sufficiently general so that they would seem to be usable with many populations.

Assessments Developed for Use with Daily Living

Skills Modules. The subject of daily living skills was the first concern of the developers of assessment methods for use with the disabled elderly. In 1963, Katz et al., developed a scale called the Index of Independence in Activities of Daily Living, or ADL, which measured toileting, bathing, feeding, transferring (as from bed to chair), dressing, and continence. Later, two types of ADL were differentiated by Lawton and Brody (1969): (1) physical maintenance activities (also referred to as physical ADL by Pfeiffer, [1975]); and (2) instrumental activities (IADL). Basic ADL consisted of functions like those measured in the ADL scale of Katz et al. (1977). The term "instrumental ADL," or IADL, was used to refer to activities not essential for self-maintenance, but failure to perform these activities meant that the elderly person required more support from others. Several subcategories of IADL were identified by Lawton and Brody (1969): using the telephone; shopping; food preparation; housekeeping; laundering; obtaining transportation; and taking medication correctly. Although defined some years ago, physical and instrumental ADL continue to be important concepts because of the obvious relationship of such activities to level of care requirements (Health Care Financing Administration, 1981; Pfeiffer et al., 1980).

Assessment devices were developed by the Program for each of the three modules intended to teach daily living skills.[3] These modules were referred to simply as ADL I, II, and III. The nature of the assessments for these modules was such that each specified as completely as possible the target behaviors to be taught in the modules because a major purpose of these assessments was to specify targets for change as well as to measure change. All ADL assessments were administered to determine admission to the module and readministered every fourth week during training to determine progress. A listing of the topics assessed and taught in each of the ADL modules appears in Table 4.1.

Table 4.1. Topics Covered in Each ADL Module.

ADL I	ADL II	ADL III
1. Oral hygiene	Laundering	Budgeting time and money
2. Bathing	Mending clothing	Meal planning and preparation
3. Hair care	Managing money	Housekeeping
4. Shaving	Meal selection	Obtaining community resources
5. Dressing	Maintaining a room and bathroom	
6. Nail care	Use of the telephone	
7. Personal eating habits		

The division of ADL topics into three levels was related to types of living situations which our clients either had (day treatment) or were expected to have after discharge (residential).

ADL I assessment. As may be seen from Table 4.1, the topics assessed and taught in ADL I consist of basic grooming tasks and eating habits. The grooming is assessed by simply asking clients when they last performed the task and then inspecting them for evidence that the activity was performed recently and correctly. Items are scored either zero or one. A score of zero means that the corresponding activity must be taught.

ADL II assessment. This assessment determines if the client can care for his or her clothing, manage small amounts of money, use a telephone, select proper meals from a cafeteria, and maintain a bedroom and bathroom (see Table 4.1). As with ADL I, the items are administered by asking questions, by inspecting the client, and by arranging performance tests. The two following samples illustrate how this procedure is done.

> Cares for own room and bath facilities—Ask client who cleans his or her room and bath facilities. Ask how often he or she dusts, sweeps, makes bed, cleans sink and tub. Ask, are facilities clean now? When possible, observe bedroom and bathroom to see if they are clean and neat. If either answers or observations show lack of performance, score 0.
>
> Dial telephone—Give client practice telephone. Ask client to dial 681-5947. Observe to see if client can dial number correctly.

Items are scored zero and one. Zeroes indicate deficiencies to be corrected.

ADL III assessment. The ADL III assessment is much longer than the other two of the ADL series and relies more on verbal responses, written and oral. For example, under "Budgeting time and money," clients are asked to account for their major expenses and to plan a daily schedule including time for daily tasks, leisure activities, and meals. Under community resources, clients are asked to state where they can get medical help, attend leisure activities, and so forth. A point system is used with these items which pinpoints deficits and provides a numerical score.

Social Skills. As with ADL, initial concern regarding social functioning of the elderly was with rather gross deficiencies of the institutionalized population. Again, the concern was with seriously pathological behavior. Social skills, as the term has come to be used in modern therapies, generally refers to more complex interpersonal behaviors.

In the Program, within the category of basic social skills, we have included both the quality and quantity of interpersonal behaviors. A socially skilled person would be one who exhibits the ability to make casual conversation when appropriate, who is able to control his or her own behavior and to influence that of others by the expression of proper and realistic affect and appropriate interpersonal behavior. Self-esteem (which we define as the ability to recognize and to state positive characteristics of oneself) was also included in the category of social skills because there are indications from the psychological literature that a positive opinion of oneself is correlated with successful social functioning (Rosenberg, 1965, 1979; Wells & Marwell, 1976). People who lack self-esteem are subassertive and are not perceived positively by others. For these reasons, a self-esteem training module and associated assessments were included in the social-skills training.

The assessments for two of the social-skills modules, Communications and Conversation Training, are presented next. The assessments for the self-esteem modules have already been discussed in the section on general-purpose assessments.

Communication Assessment. The assessment was made by trained observers, observing clients in two standard role-play situations (Patterson, Smith, Goodale, & Miller, 1978). As with the ADL modules, the assessment directly measured the skills taught in the module. Training focused on teaching clients to express pleasure and displeasure effectively and appropriately to another person, and this is what was portrayed and measured in the role-play. This assessment device was used during training for each role-play to provide a basis for feedback and reinforcement; it was also used in special, nontraining sessions every four weeks to provide program scores for evaluations and clinical purposes. No coaching, reinforcement, or feedback occurred in these latter sessions.

The actual assessment instrument was a very simple rating scale modeled after that described by Liberman, King, DeRisi and McCann (1975). Although more complex and presumably more precise measures, such as timing eye contact from videotapes (Hersen & Bellack, 1978) and measuring speech volume electronically (Patterson, Teigen, Liberman, & Austin, 1975), have been developed (see Bellack & Hersen, 1979, for a review of this area), these were not deemed appropriate for the Program because they do not provide sufficiently rapid feedback or they require more sophisticated observers and equipment than were available. Previously developed self-report measures were also not considered useful, primarily because almost all of them were developed for use with college students.

Ratings for both pleasure and displeasure situations were made on each of seven items. Each of these items was scored on a 6-point scale ranging from "1" (completely inadequate or inappropriate) to "6" (completely appropriate and strongly emphatic). Of the seven items included, three rated verbal aspects of performance: content, loudness, and voice quality; and three rated nonverbal aspects: hand gestures, body position, and facial expression; the seventh item was a rating of overall performance.

Conversation assessment. Two different assessments were employed in Conversation Testing. One (employed sessional assessment) provided sessional indicators of frequency of conversation during training; the other measured generalization. The sessional assessment consisted of an interval-recording procedure. Clients were all seated in the dayroom so that they could be easily observed. Several observers were each assigned five or six clients. For every other 30-second interval, observers recorded whether or not the client was observed conversing. These data were used as the basis of feedback and reinforcement and also provided sessional indicators of progress.

The generalization measure was administered every fourth week. A time-sampling procedure was employed. Clients were observed wherever they happened to be on the unit at times when no other formal activity was scheduled (such as after dinner for residential clients and during a break after lunch for the day clients.)

INTERVENTIONS

The Aging Program is a total mental-health treatment approach of which the ADL and social-skills modules are a central component. It is true that the entire group of modules, or any of them, could be applied in isolation from the other treatment components. However, this is not recommended. We believe that all of the treatment components should be coordinated with each other and considered as integrated parts of a total approach. It is very poor practice to apply several different uncoordinated approaches to the same individual.

The behavioral model provided the unifying conceptual framework as well as most of the technology of the Program. Medical interventions were used very frequently, but when these were used to address behavioral problems such as delusional talk, every effort was made to define and to measure the problem in behavioral terms. Likewise, social-work services were strong and very valuable to the Program, but again, the focus was on the behavior of the individual in relation to other people and in relation to specific social settings.

The Program employed three facets of behavioral technology in the overall intervention: (1) the modules described in this chapter; (2) a token economy, which is a widely used system of motivating people to perform within treatment programs (Atthowe & Krasner, 1968; Ayllon & Azrin, 1968; Patterson, 1976) in which staff provide clients with objects or points that may be exchanged at later times for rewards or reinforcers (such as soft drinks, toilet items, or extra time with a therapist); and (3) a basic behavioral approach to a variety of difficulties experienced by clients. To provide this unified behavioral orientation to intervention, all staff members were given 30 hours of instruction in behavioral concepts and techniques. In addition, the modules and various other structured activities and individually prescribed behavioral treatments were taught. This training provided the staff with the knowledge and skills needed to implement the Program.

The combination of these basic behavioral approaches was used not only within the formal training sessions but also throughout the entire Program. Thus, idiosyncratic problem behaviors shown by particular individuals that were not part of the content of the training modules could be dealt with outside of the formal training sessions. And skills learned during formal training sessions could be maintained and generalized outside training sessions by reinforcing the behaviors wherever they occurred. In practice, many skills of many clients improved rather rapidly within the training sessions and generalized rather well without much special effort. We assume that this occurred because, in most cases, the clients had learned and generalized many of these skills earlier in life and had stopped performing them relatively recently.

The consistent behavioral approach carried over to our work with families. Rather than deal in generalities, an effort was made to determine quite specifically what the client was or was not doing and/or what the family was or was not doing that made life difficult. For example, in one case it was discovered that a daughter-in-law objected strongly to her husband's mother's "disgusting eating habits and hostile remarks." The mother, in turn, had difficulty eating because of an inability to use one arm. She also had complaints about the home. It was possible to overcome the eating problem by training the client to have more acceptable eating habits, with which, however, she required some assistance. The family was likewise instructed how to assist her with eating. The hostile verbal behavior was decreased by teaching the mother more appropriate ways to express herself by means of social-skills training. Long-term placement back in the home was the outcome.

Structure, Content, and Methodology of the Modules

Each module exists in the form of a manual.[4] The contents of these are described briefly in this section. The format for the manuals follows this outline:

- I. *Introductory Material*
    - A. Statement of what is to be taught to whom.
    - B. Basics of relevant behavioral techniques.
- II. *Main Body*
    - A. Content to be taught.
    - B. Specifics regarding technique.
    - C. Necessary equipment and aids.
- III. *Assessment and Recording Material*
    - A. Assessment instrument and technique
    - B. Data-recording forms.

Each manual contains an introduction telling what the module is designed to teach to what type of client. This is followed by a section assessing the user's skills in relevant behavioral techniques, including a discussion of how to explain these techniques to the client. The main body of the module contains a description of the content to be taught, specific target behaviors to be acquired, an explanation of specific teaching techniques to be employed, and a list of equipment and teaching aids to be used. The final section of each manual consists of the assessment methods, materials and instruments, and data-recording forms.

There are several advantages to having predesigned modules. They provide supervisors of treatment programs with a complete set of materials regarding program content and staff activities. They make it relatively simple to check if trainers are indeed teaching specified skills in the specified ways. The assessments and data forms make it possible to determine whether individual clients, or groups of clients, are acquiring the desired skills. The trainers themselves also have an easier job; the manuals inform them: (1) which clients need to achieve better functioning; (2) how to achieve such improved functioning; and (3) how to establish that this has actually been accomplished.

It is important to realize that the basic techniques used in all six modules were the same, regardless of the content. All modules employed well-established behavioral techniques. The three basic techniques shared by all modules were: (1) instruction or prompting; (2) practice; and (3) reinforcement (see Skinner, 1968). Instruction was accomplished by verbal instructions, modeling, and motor guidance. Verbal instructions were initiated by the trainer, but clients could also instruct each other in some situations. Group discussions were also used. A very important point was that all verbal instruction had to be brief and well circumscribed. Discussions beyond a few minutes were to be avoided. Modeling was accomplished by having either staff or another client demonstrate the desired behavior or some component thereof. Motor guidance, which refers to having a staff person physically guide a client to accomplish some act, was used sometimes but was discontinued as soon as possible. Reinforcement was of two types, social and token. Trainers always immediately recognized and praised correct performance. When tokens were given, the recipients were always reminded exactly how they had earned them and praised for these accomplishments.

These techniques were used to shape and to chain behaviors. Shaping refers to producing correct behaviors by reinforcing a series of increasingly correct approximations to the desired behavior. Chaining refers to learning a complete act by first learning specific components of that act in a correct series. The series may either begin with the first (forward chaining) or last step (backward chaining) required.

ADL I. This training was provided to groups of one to eight people for one hour each day, five days a week. An instructor and an assistant were involved. Where modesty required, men and women were trained separately; and the act of bathing was always performed with only the client and a same-sex trainer present. As with all modules, special assignments of ADL I activities were made to promote generalization and maintenance as needed. The training was divided into seven separate "information units," one of which was presented on a given day, depending upon the deficits and progress of the assigned trainees. These seven units contained outlines of material to be taught which corresponded to the topics presented in Table 4.1. Included were oral hygiene, bathing, hair care, shaving, dressing, nail care, and personal eating habits. A bathroom, hair dryer, manicuring equipment, and other equipment normally needed to perform these tasks were required.

Each session began with a demonstration accompanied by appropriate verbal instruction. Brief group discussion was encouraged. Trainees were first reinforced for responding verbally as to how and why to perform the correct behavior. Then, individuals assessed as requiring practice performed the correct behavior with additional instruction as needed. Reinforcement was always contingent upon correct performance.

1. Mrs. Jones is your neighbor and she heard you were ill, so she brought you some food she cooked. Express your appreciation to her.

2. Mr. Smith lives in the room next to yours, and he plays his radio very loudly late at night. Tell him you don't like this and ask him to stop doing it.

Two clients then role-played the actor and the recipient of the action. Role-playing was followed by a request from the leader for feedback from the group as to what the actor did well, followed by a request for feedback as to what behaviors needed improvement. Group members were reinforced socially for feedback and reinforced with tokens for giving accurate feedback. The role players were similarly reinforced, but with more tokens, for their participation. After feedback was obtained from the group, the actor was asked to enter the ratings earned on the large rating board on the wall. This procedure was followed by a second role-play of the same scene, either by the original actor or by a model. Models were used at the discretion of the leader when the leader felt that a demonstration of correct performance was required. If a model was used, the second role-play was followed by a feedback session like the first. Whether or not a model was used, the original actor was given a second chance to perform the same scene. This final role-play was always accompanied by a final feedback session that was directed first toward improvements the actor made over the original role-play and then toward additional improvements that could be made in the future.

At the conclusion of the session, all clients were informed of their accomplishments (role playing and/or feedback) and reinforced with tokens. This procedure was continued until clients were able to obtain ratings of four or above on every item during special fourth-week assessment role-plays. In these latter sessions minimal instructions were used, and no reinforcement or feedback was given.

Conversation Training. This training differed from the others in that it involved very little verbal instruction and no modeling or demonstrations.

Fifteen to 20 clients were assembled in a large dayroom and instructed to spend the next 30 minutes getting to know each other and conversing with each other about anything they chose. They were further informed that someone would come at various times and give them tokens and feedback if they were conversing. Observers were stationed around the room and given the task of observing clients according to an interval-recording procedure. These observers administered social and token reinforcements according to a variable interval schedule averaging one reinforcement every five minutes.

Self-Esteem Training. This training was provided to clients meeting in groups of 10 or fewer. After a brief explanation of the purpose of this module, the group was told that they were to "accentuate the positive and eliminate the negative" (i.e., that they were to say only good things about themselves and about each other). Since modesty was regarded as a virtue by many, it was necessary to explain to the group that although they may have learned modesty early in life (and it is appropriate at times), it is also important that one be able to be truthful with oneself and with others about what we believe our good characteristics to be. A variety of prompts were used to elicit positive statements. For example, clients were asked what someone should say if they were to write a letter of recommendation for them or to mention the three personal characteristics that they would least like to change. Tokens and social reinforcement were given for appropriate statements. Inappropriate statements, such as "There's really nothing good about me," were put on extinction by being ignored and the leader's attention being directed towards someone else. Attempts were made to elicit at least one positive self-statement from each person in every session. Social reinforcement by group members to each other's positive statements was also actively prompted and reinforced by the leader. Often clients' responses would focus on general traits such as kindness and honesty. These were reinforced, but the leader prompted the client to report recent specific examples illustrating these qualities rather than to leave them as vague generalities. The goal of the group was to increase the number of different, positive attributes rather than merely to repeat the same qualities over and over.

Individually based Interpersonal Skills Training. In addition to the modules described above, additional skills training was provided to many clients as needed. If the staff and client agreed that there was a particular interpersonal problem in the client's life, then the same basic methodology of role playing, feedback, and modeling was used to correct the problem. For example, a client had been placed, against her wishes, in a rather restrictive boarding home in an isolated location "for her own good" because she had at one time exhibited some confusion. As time for discharge from the Program approached, the client and the staff felt that she did not need to return to such a restrictive placement, but that the client would have to convince her relatives that this was the case. The client was a rather meek woman who had difficulty not giving in to her much stronger relatives. After a dozen or so sessions of training, the client stated her case appropriately and effectively and she was able to convince the relatives to help her find a more suitable place to live.

A CASE STUDY

Partial case studies were presented earlier to illustrate specific points. However, a more complete case study will be presented here to illustrate how the assessments, modules, and other activities were used as a treatment package.

BEST COPY AVAILABLE

A 60-year-old man, Joe, came to the Program after having been in a state hospital continuously for the previous year where he was diagnosed as having chronic schizophrenia, undifferentiated type. He complained currently of "nerves" and arthritis in the right knee. He had a history of several psychiatric hospitalizations during the past eight years, beginning with an arrest for stealing, which he claimed was to get food. The physical examination showed Joe to be in good health. His interview behavior was passive, and he displayed flat affect and depressed mood. He was expressionless, with decreased motor activity and some peculiar posturing. His speech was reduced in amount, slow, and soft. He expressed delusions of reference. There was some impairment of orientation to time. The interviewer estimated his intellectual functioning to be below normal and noted that his insight and judgment were poor.

The social-skills modular assessments, made at time of admission, showed major deficits. In the conversation sessional assessment, he scored zero, then 2 out of 30 on two baseline measures. The generalization measure revealed that he was solitary and failed to interact. In communications, he made the lowest possible overall score; 1 out of 6 on the overall rating for both pleasure and displeasure. Somewhat suprisingly, he failed to show any deficit in ADL I; but deficits were found in ADL II, including mending clothing, handling spending money, and dialing a telephone. The life-satisfaction and self-esteem scores were also moderately low. In addition to the problems dealt with in these six modules, he had trouble recalling the date and the time.

The interventions in this case were all behavioral and social. Joe had been taking antipsychotic medication for several months in the state hospital before admission to the Program, and it was decided to continue the medications. Joe was admitted to all three social-skills modules and ADL II. In addition, he was given training for the problem with dates and with participation in leisure-time activities. He was also assigned to a group for discussing current events.

Four weeks later, Joe had made considerable progress. Conversation sessional assessments showed that he was conversing *22 out of 30 intervals measured in a sample session*. There was also similar improvement on the generalization measure. Ratings on the communication assessment increased to 4 (a good performance, though not very emphatic) on pleasure and to 6 (the maximum rating) on displeasure. Unfortunately, his improvement in self-esteem was not as good, there being very little improvement on the fourth-week assessment. By the fourth week he had learned the skills to overcome his previous deficits in ADL II and he was entered into ADL III. Subsequent to these intial improvements, progress was limited. Joe did not progress well in ADL III, and so he was discontinued from this training. In the social-skills area, he completed Communication Training in about two and one-half months and was offered an opportunity for interpersonal problem solving. He thought that this latter training was silly and he declined. He remained in self-esteem training throughout his stay, but his performance was always sporadic, and little, if any, progress was made in this area.

Joe's scores on the NOSIE-30 and the CAP generally paralleled the module assessments. He improved on all of the scores of the NOSIE and the CAP.

Overall, it seemed that he improved quite a bit in basic social skills and somewhat in ADL skills, but that he did not progress in the more advanced, more highly verbal areas. This information helped to determine that a mildly sheltered placement was needed for Joe. Upon discharge, after four and one-half months in the Program, Joe went to live in a boarding home. Follow-up 12 months after discharge found him still residing in the same home without further need for institutional care.

NOTES

1. Many of these ADL deficiencies were associated with a loss of ambulation and mobility.
2. FMHI is a state-funded organization, having as its mission the development of innovative approaches and the dissemination of useful methodology to the state's mental health system.
3. Originally designed for use with these modules, extensive reliability and validity testing has shown these to be moderately reliable and valid for this population. Further detail regarding this is available in Patterson, Dee-Kelly et al. (in press).
4. For additional information, the reader should see the recent book by Patterson, Dee-Kelly et al. (in press) The reader may also write to the first author of this chapter for additional information.

REFERENCES

Atchley, R. C. *The social forces in later life: An introduction to social gerontology.* Belmont, Calif: Wadsworth, 1977.

Atthowe, J. M., & Krasner, L. Preliminary report on the application of contingent reinforcement procedures (token economy) on a "chronic" psychiatric ward. *Journal of Abnormal Psychology,* 1968, 73, 37–43.

Ayllon, T., & Azrin, N. *The token economy: A motivational system for therapy and rehabilitation.* New York: Appleton-Century-Crofts, 1968.

Baffa, G. A., & Zarit, S. H. *Age differences in the perception of assertive behavior.* Paper presented at the 30th Annual Meeting of the Gerontological Society, San Francisco, 1977.

Baltes, M. M., & Barton, E. M. New approaches toward aging: A case for the operant model. *Educational Gerontology,* 1977, 2, 383–405.

Baltes, M. M., Burgess, R. L., & Stewart, R. B. *Independence and dependence in nursing home residents: An operant-ecological study.* Paper presented at the 1st NOVA Behavioral Conference on Aging, Port St. Lucie, Florida, May 21-25, 1978.

Baltes, M. M., & Zerbe, M. B. Independence training in nursing home residents. *The Gerontologist,* 1976, 16, 428–432.

Bates, H. D. *Gerontology proposal.* Tampa, Fla.: Florida Mental Health Institute, 1975.

Bellack, A. S., & Hersen, M. (Eds.). *Research and practice in social skills training.* New York: Plenum, 1979.

Bernal, G., Brannon, C., Belar, J., & Cameron, R. Psychodiagnostics of the elderly. In W. D. Gentry (Eds.), *Geropsychology: A model of training and clinical service.* Cambridge, Mass.: Ballinger, 1977.

Birren, J. E., Butler, R. N., Greenhouse, S. W., Sokoloff, L., & Yarrow, M. R. (Eds.). *Human aging.* Washington, D.C.: U.S. Government Printing Office, 1963.

Blazer, D. G., & Maddox, G. Using epidemiologic survey data to plan geriatric mental health services. *Hospital and Community Psychiatry,* 1982, 33, 42–45.

Butler, R. N., & Lewis, M. I. *Aging and mental health.* St. Louis, Mo.: Mosby, 1973.

Butler, R. N., & Lewis, M. I. *Aging and mental health.* St. Louis, Mo.: Mosby, 1977.

Cairl, R. The elderly: Health studies and health utilization patterns. In *Community health policy information study,* Research Triangle Park, N.C.: Research Triangle Institute, in press.

Campbell, D. T., & Fiske, D. W. Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin,* 1959, 56, 81–105.

Campbell, D. T., & Stanley, J. C. *Experimental and quasi-experimental designs for research.* Chicago, Ill.: Rand-McNally, 1963.

Corby, N. H. Assertion training with elderly populations. *Counseling Psychologist,* 1975, 5, 69–73.

Curran, J. P., & Wessberg, H. W. Assessment of social inadequacy. In D. Barlow (Ed.), *Behavioral assessment of adult disorders.* New York: Guilford, 1981.

Duke University Center for the Study of Aging and Human Development. *Multidimensional functional assessment: The OARS methodology.* Durham, N.C.: Author, 1978.

Eberly, D. A., Patterson, R. L., Jackson, G. M., & O'Sullivan, M. J. *Survey of residents of G. Pierce Wood Memorial Hospital aged 55 and older.* Tampa, Fla.: Gerontology Program, Florida Mental Health Institute, University of South Florida, 1981.

Eisler, R. M. The behavioral assessment of social skills. In M. Hersen & A. Bellack (Eds.), *Behavioral assessement.* New York: Pergamon, 1976.

Farina, A., Arenberg, D., & Guskin, S. A scale for measuring minimal social behavior. *Journal of Consulting Psychology,* 1957, 21, 265–268.

Florida Department of Health and Rehabilitative Services, Alcohol, Drug Abuse and Mental Health Program Staff. *Client assessment survey.* Tallahassee: Author, September 1981.

Goldstein, A. P., Sprafkin, R. P., & Gershaw, N. J. *Skill training for community living: Applying structured learning therapy.* New York: Pergamon, 1976.

Gurel, L., Linn, M. W., & Linn, B. S. Physical and mental impairment of function evaluation in the aged: The PAMIE scale. *Journal of Gerontology,* 1972, 27, 83–90.

Health Care Financing Administration. *Long-term care: Background and future directions.* January 1981.

Hendricks, J., & Hendricks, C. D. *Aging in mass society: Myths and realities.* Cambridge, Mass.: Winthrop, 1977.

Hersen, M., & Bellack, A. S. Assessments of social skills. In A. R. Cimenero, K. S. Calhoun, & H. E. Adams (Eds.), *Handbook for behavioral assessment.* New York: Wiley, 1978.

Hersen, M., Eisler, R., & Miller, P. *Progress in behavior modification.* New York: Academic Press, 1980.

Hogarty, G. E., & Ulrich, R. The discharge readiness inventory. *Archives of General Psychiatry,* 1972, 26, 414–426.

Honigfeld, G., Gillis, R. D., & Klett, C. J. The nurse's observation scale for inpatient evaluation. *Journal of Consulting Psychology,* 1966, 22, 69–77.

Katz, S., Downs, T. D., Cash, H. R., & Grotz, R. C. Progress in development of the index of ADL. *The Gerontologist,* 1977, 10, 20–30.

Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. Studies of illness in the aged. The index of ADL, a standardized measure of biological and psychosocial function. *Journal of the American Medical Association,* 1963, 185, 914–919.

Kleban, M., Lawton, M. P., Brody, E. M., & Moss, M. Behavioral observations of mentally impaired aged: Those who decline and those who do not. *Journal of Gerontology,* 1976, 31, 333–339.

Kuypers, J. A., & Bengston, V. L. Social breakdown and competence. *Human Development,* 1973, 16, 181–201.

Larson, R. Thirty years of research on the subjective well-being of older Americans. *Journal of Gerontology,* 1978, 33, 109–129.

Lawton, M. P. Assessment, integration, and environments for older people. *The Gerontologist,* 1970, 10, 38–46.

Lawton, M. P., & Brody, E. M. Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist,* 1969, 3, 179–186.

Lewinsohn, P. M., Biglan, A., & Zeiss, A. M. Behavioral treatment of depression. In P. O. Davison (Ed.), *The behavioral management of anxiety, depression and pain.* New York: Brunner-Mazel, 1976.

Liberman, R. P., King, I. W., DeRisi, W. J., & McCann, M. J. *Personal effectiveness: Guiding people to assert themselves and improve their social skills.* Champaign, Ill.: Research Press, 1975.

Libet, J. M., & Lewinsohn, P. M. Concept of social skills with specific reference to the behavior of depressed persons. *Journal of Consulting and Clinical Psychology,* 1973, 40, 304–312.

Linn, M. W. Assessing community adjustment in the elderly. In A. Raskin & L. Jarvik (Eds.), *Psychiatric symptoms and cognitive loss in the elderly.* Washington, D.C.: Hemisphere, 1979.

Lowenthal, M. F. Social isolation and mental illness in old age. *American Sociological Review,* 1964, 29, 54–70.

Maddox, G. L. Self-assessment of health status: A longitudinal study of selected elderly subjects. *Journal of Chronic Diseases,* 1964, 17, 449–460.

McClannahan, L. E., & Risley, T. R. A store for nursing home residents. *Nursing Homes,* 1973, 7, 26–31.

Michaux, M. M. *Comparative study of day treatment vs. inpatient treatment.* Sykesville, Md.: Research Department, Springfield State Hospital, 1971.

Miller, L. M. Toward a classification of aging behaviors. *Gerontologist,* 1979, 19, 283–290.

Neugarten, B., Havighurst, R., & Tobin, S. The measurement of life satisfaction. *Journal of Gerontology,* 1961, 16(2), 134–143.

O'Sullivan, M. J., Eberly, D. A., Patterson, R. L., & Penner, L. A. *An experimental study of improving life satisfaction of older people by increasing self-esteem through behavioral training.* Paper presented at the 26th Annual Meeting of the Southeastern Psychological Association, New Orleans, 1979.

Patterson, R. L. (Ed.). *Maintaining effective token economies.* Springfield, Ill.: Charles C. Thomas, 1976.

Patterson, R. L., Dee-Kelly, C., Dupree, L. W., Eberly, D. A., O'Sullivan, M. J., & Penner, L. A. *Overcoming deficits of aging: A behavioral treatment approach.* New York: Plenum, 1982.

Patterson, R. L., & Jackson, G. M. Behavior modification with the elderly. In M. Hersen, R. M. Eisler, & P. Miller (Eds.), *Progress in behavior modification,* Vol. 9. New York: Academic Press, 1980.

Patterson, R. L., Penner, L. A., Eberly, D. A., & Harrell, T. L. Behavioral assessments of intellectual competence, communication skills, and personal skills of elderly persons. *Behavioral Assessments,* in press.

Patterson, R. L., Smith, A. G., Goodale, P., & Miller, C. *Improving communication abilities in psychogeriatric clients.* Paper presented at the 29th Annual Meeting of the Southeastern Psychological Association, Atlanta, 1978.

Patterson, R. L., Teigen, J. R., Liberman, R. P., & Austin, N. Increasing speech intensity of chronic patients ("mumblers") by shaping techniques. *The Journal of Nervous and Mental Disease,* 1975, 3, 182–187.

Pfeiffer, E. *Functional assessment: The OARS multidimensional functional assessment questionnaire.* Durham, N.C.: Duke University Center for the Study of Aging and Human Development, 1975.

Pfeiffer, E. Psychopathology and social psychology. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging.* New York: Van Nostrand Reinhold, 1977.

Pfeiffer, E., Johnson, T. M., & Chiofolo, R. C. *Functional assessment of elderly subjects in four service settings.* Paper presented at the 33rd Annual Meeting of the Gerontological Society, San Diego, Calif.: November 1980.

Phillips, E. L. *The social skills basis of psychopathology: Alternatives to abnormal psychology.* New York: Grune & Stratton, 1978.

Rosenberg, M. *Society and the adolescent self image.* New York: Basic Books, 1965.

Rosenberg, M. *Conceiving the self.* New York: Basic Books, 1979.

Skinner, B. F. *The technology of teaching.* New York: Appleton-Century-Crofts, 1968.

Smith, J. M. Nurse and psychiatric rating scales for assessing psychopathology in the elderly: A critical review. In A. Raskin & L. Jarvik (Eds.), *Psychiatric symptoms and cognitive loss in the elderly.* Washington, D.C.: Hemisphere, 1979.

Ulmer, R., & Lieberman, J. The children's minimal social behavior scale: A short objective measure of personality functioning. *International Journal of Psychology,* 1970, 5, 269–274.

Wells, L., & Marwell, G. *Self-esteem: Its conceptualization and measurement.* Beverly Hills, Calif.: Sage, 1976.

Zarit, S. H. *Aging and mental disorders.* New York: Free Press, 1980.

The experience of a Geropsychiatric Outreach Team that evaluated and treated psychiatrically impaired elderly in the natural setting of their home is described, and information from initial diagnostic reports and three month follow-up interviews on the first 66 patients is examined. Findings suggest that the majority of patients had improved or stabilized, and most were able to be maintained in the community. Intervention strategies and the characteristics of patients who improved, became stabilized, or did not benefit from the Outreach program are discussed.

Key Words: Geropsychiatric outreach, Psychiatrically impaired elderly, Home evaluation

Home Evaluation of Psychiatrically Impaired Elderly: Process and Outcome[1]

Wendy Wasson, MSW,[2] Andrew Ripeckyj, MD,[3] Lawrence W. Lazarus, MD,[4]
Sylvia Kupferer, RN,[5] Suzanne Barry, RN,[6] and Farid Force, MD[7]

Home psychiatric evaluation and treatment services have been seen as helpful in treating elderly patients who might not otherwise enter traditional mental health programs until a crisis necessitates hospitalization. Outreach provides diagnosis and treatment for elderly who are homebound because of physical limitations, social isolation, and major psychiatric problems such as dementia, paranoia, and depression. Home evaluation may be more comfortable and less threatening for the vast number of eldery people who are fearful of psychiatric care (Selan & Gold, 1980), and may minimize disruption and premature institutionalization of the aged patient (Kahn & Tobin, 1981; Raskind et al., 1976; Reifler et al., 1982).

In 1980 a Geropsychiatric Outreach Team was developed at the Illinois State Psychiatric Institute (ISPI). The Outreach Team was available to psychiatrically impaired people over the age of 60 who resided in the city of Chicago. To ensure a multidisciplinary approach, the team consisted of a psychiatric nurse, a social worker, and a psychiatrist. The team conducted a one- or two-visit comprehensive biopsychosocial assessment and formulated and implemented a treatment plan which involved linking the older patient with available medical, mental health, and social services in the community. Follow-up evaluation interviews were conducted 3 months after the team's initial contact to assess the impact of their intervention.

Patient Profile

The 83 patients evaluated in the first 11 months of the team's operation were referred primarily by home health professionals who already had significant contact with the older person. Referrals to the program were made for a wide variety of problems, including depression, confusion, and bizarre behavior. Referrals also included patients who were inattentive to serious health, financial, or other problems of daily living. Others were referred for being excessively demanding, dependent, or aggressive.

The mean age of patients was 77, with a range from 60 to 94. Although socioeconomic status varied from destitute to wealthy, most patients were subsisting on Social Security benefits and small pensions. The majority of our patients were female (71%) and single (80%). Of the single patients, 60% were either widowed or divorced, 20% were separated from their spouse, and 20% had never married. Thirty-five percent of the patients were black, 63% were white, and the remaining 2% were of other racial groups. Nearly one-quarter of the patients were immigrants. Living arrangements were divided almost equally among those who lived with relatives (35%), those living in their own apartments or homes (34%), and those in senior citizen and public housing (31%). Finally, 45% of our first 83 patients were childless and 60% were reliant on extended kin and surrogate families (friends, agency personnel, building managers).

---

[1] This project was supported in part by a grant from the Chicago Community Trust. The authors express appreciation to Dr. Kenneth Sakauye for his review and suggestions, to Mr. Russell Pitts for computer analysis, and to Ms. Alice Ras, Ms. Catharina Sabo, and Ms. Lovie Brown for their assistance in the preparation of the manuscript. At the time this paper was developed, all authors were members of the Geropsychiatric Program, Illinois State Psychiatric Institute, 1601 W. Taylor Street, Chicago, IL 60612.

[2] Chief Psychology Resident, Northwestern Memorial Hospital, Department of Psychiatry, Superior Street and Fairbanks Court, Chicago, IL 60611.

[3] Director, Geropsychiatric Outreach Program, Illinois State Psychiatric Institute, and Assistant Professor of Psychiatry, Rush Medical College, Chicago, IL 60612.

[4] Director, Geropsychiatric Program, Illinois State Psychiatric Institute and Assistant Professor of Psychiatry, Rush Medical College, Chicago, IL 60612.

[5] Coordinator, Geropsychiatric Outreach Program, Illinois State Psychiatric Institute.

[6] Supervisory Nurse, Geropsychiatric Program, Illinois State Psychiatric Institute.

[7] Director, Geropsychiatric Outpatient and Outreach Program, Illinois State Psychiatric Institute.

Process of Intervention

An understanding of the patient's medical, psychological, and social functioning was required in order to plan active interventions. Assessment always proceeded from an attempt to understand the needs and perspective of the older patient. Recommendations were flexibly directed toward that part of the patient's life that was open to change. The complex nature of these cases was reflected in the great variety of recommendations made to the patient and responsible others.

Direct psychiatric services (psychotherapy, psychotropic medication, psychiatric hospitalization, evaluation for guardianship) were recommended in 77% of the cases. In 47%, however, the main recommendations were for increased medical or social services. Finally, consultation with significant others and professionals existed to some extent in most situations (80%). Checking back with referral sources and communication of the team's ideas were important steps in the assessment phase and were crucial for the successful implementation of treatment recommendations.

Outcome in Three Improvement Categories

Information was obtained during the evaluation interview pertaining to a number of variables. Each patient's age, sex, and a listing of presenting problems were recorded, as were the Diagnostic and Statistical Manual of Mental Disorders (DSM) III, Axis I diagnosis (American Psychiatric Association, 1980), mental status score (Kahn et al., 1960), and treatment recommendations. More than one DSM III diagnosis, presenting problem, or type of intervention was recorded for each patient. The diagnosis and treatment recommendation were made by one member of the team in consultation with the other team members.

Patients were then assigned to 3 improvement categories. The 3 general improvement categories summarized our perception of the patient's status at 3-month followup based upon an in-person interview with the patient, discussion with significant others, and discussion by the Outreach Team. The final assessment of outcome was made by one team member in consultation with the team psychiatrist. Patients were placed in the "Improved" category if a decrease in symptoms and an increase in the patient's sense of well-being appeared and/or a marked reduction occurred in the tension between the older person and significant others. Thus, cases would not be considered "Improved" if placement or institutionalization of the older person resulted only in emotional relief for others. If the older person also reported feeling satisfied with the new arrangement, the outcome was rated "Improved." The "Stable" category included situations in which the older person remained in the community and tension in the social environment was diminished, but without major improvements in symptoms or sense of well-being. The "Unimproved" category included cases in which symptoms, problems, or tensions persisted or worsened, causing extreme discomfort to the identified patient and/or significant others.

In many instances, evaluations of outcome were difficult, given the patients' rapidly changing medical, psychological, and social conditions. Due to death (4), insufficient information (3), or hospitalization (10), 17 patients could not be included in the following discussion of outcome.

Improved Cases

Of the 66 cases reevaluated at 3 months, 34 (52%) were "Improved." These patients had been referred for a wide range of presenting problems including symptoms that concerned other persons in the patient's environment (e.g., depression, poor self-care, confusion) or behaviors that bothered others (e.g., flooding an apartment, striking out at people).

Likewise, cases showing symptomatic improvement included a wide variety of psychiatric diagnoses. Of the 34 patients who had improved, 50% had primary or secondary diagnoses of dementia, 32% had depressive disorders, and 21% had paranoid disorders. A striking finding was that demented patients comprised the group which demonstrated the most improvement. Although these patients still exhibited a similar degree of cognitive dysfunction at followup, they nonetheless appeared to be calmer and less symptomatic and were more manageable.

One of the distinctive characteristics of the "Improved" cases was that either the patient or significant other generally accepted, supported, or acted upon the recommendations of the team. More frequently than in the other two outcome groups, "Improved" patients and their responsible others exhibited a willingness to become engaged in the process of evaluation and treatment planning.

Many types of interventions were associated with improvement. Consultation with significant others (relatives, building managers, etc.) occurred in 16 of the 34 cases that were considered "Improved" and was aimed at providing information and support in order to mobilize these individuals to take action. One of the particularly important functions of the team was to help the significant other to understand the needs and perspectives of the older person.

Consultation with professionals working with the older patient was another important intervention strategy. Although most of the patients referred to the team were already involved with social agencies, they presented confusing psychiatric symptoms or problems. Just as our Outreach team became involved with the patient's family and significant others, it was also crucial to discuss the type and intensity of the professional's involvement with the patient. Thus, in addition to suggesting increased services or support, the team frequently advocated that other involved professionals respect the older person's autonomy. Professionals sometimes needed permission to curtail their activities, thereby reducing their involvement, expectations, and goals for the patient without complete withdrawal. The case described below illustrates this strategy.

Ms. H., a 73-year-old widowed white woman with paranoid schizophrenia, was referred to the Outreach Team by a social worker who was uncertain of Ms. H.'s aggressive potential. She also wanted help in developing an appropriate treatment plan. After meeting with Ms. H., the team shared its evaluation of the patient's impulse control and suggested a non-intrusive, therapeutic approach that would allow Ms. H. to move into a relationship on her own terms. This helped to reduce the worker's anxiety and expectations for herself and the client. In addition, the team's continued availability enabled the social worker to engage more comfortably with the client.

Linkage to psychiatric outpatient therapy was associated with improvement in 7 cases. Medication was also useful in reducing psychiatric symptoms (e.g., depression, paranoia, hallucinations) in 11 cases. The following vignette illustrates the impact of the combined intervention of consultation, linkage to outpatient psychotherapy, and initiating psychotropic medication.

Ms. M., a 64-year-old woman, was threatened with eviction from her public housing facility after she repeatedly flooded her apartment and banged on the walls. After the initial evaluation, the team discussed the situation with a social worker from a nearby mental health center who gradually developed a therapeutic relationship with the patient. Neuroleptic medication was also used. The landlord agreed to postpone eviction pending the outcome of psychiatric treatment. Three months later, Ms. M. was still living in her apartment. She greeted the team members warmly, speaking highly of her therapy and describing how much better she was feeling.

It is significant that recommendations for outpatient psychiatric treatment, although potentially helpful, were frequently not accepted by patients because of fear, lack of motivation, or their psychiatric problem. The task of linkage was much easier and more successful when agencies or clinics could provide ongoing psychological services in the person's home.

Positive outcome occurred in 6 of the 34 "Improved" cases when medical or psychiatric hospitalization was facilitated. The team was frequently asked to assess patients who were in psychiatric crisis or who were physically very ill. Commitment to a psychiatric hospital was sometimes necessary and the team had to help the older patient and family work through their resistance to hospitalization. The support of the team seemed to motivate responsible others who were previously immobilized by either guilt or indecision. The team also helped bring about action in situations where there were no close family members and/or clear lines of responsibility.

Nursing home placements ultimately occurred in 8 of the first 66 cases assessed at followup, usually at a point where the psychological or physical needs of the patient far outweighed the capacity of helping others or the milieu to provide necessary support. Placement was usually approached with reluctance by the patient as well as responsible others. Surprisingly, however, all but one of these patients showed improvement. The following case illustrates how a chronically impaired man adjusted positively to placement.

Mr. W., a 68-year-old bachelor who was camped out on a sofa in the middle of his "mean" sister's apartment, had fears of breathing toxic fumes and would not get up off the sofa even though roaches crawled over his legs. He was dehydrated and malnourished. His sister begrudgingly brought him food daily. Despite our attempts at facilitating family communication and a rational approach to these problems, Mr. W.'s sister eventually threw him out on the street. The team facilitated hospitalization and placement in a nursing home. At his 3-month assessment interview, Mr. W. warmly recalled who we were (despite our not having controlled his sister as he had wanted) and seemed to have established a court of attentive nurses. Although he enjoyed the activity of his new residence, he talked of his hope that he would finally secure a place of his own.

Stabilized Cases

Fourteen (21%) of the 66 patients were assessed as having stabilized at the 3-month followup. These patients had been referred primarily for problems in self-care (nutrition, health, housekeeping), confusion (impaired memory), and bizarre behavior and ideation. Diagnostically, no patients had a primary diagnosis of affective disorder, 7 cases (50%) had senile dementia, 4 cases (29%) had paranoid disorders, and 1 case (7%) had schizophrenia.

Recommendations and interventions in this "Stabilized" group focused more frequently on consultation with professionals and the initiation of guardianship procedures. For patients who had more involved social support systems, however, consultation and coordination of services were utilized to keep the older person in the community as long as possible.

One of the main intervention strategies of our team was to provide active support for the responsible other(s) through the use of empathy, suggestions, and the offer of continued availability. The following vignette illustrates this process.

Ms. C., a 75-year-old single retired career woman living in her own home, was increasingly unable to manage her own affairs. However, she was under the vigilant care of a boyfriend who visited daily and a sister who also assisted. Friction resulted because a brother who had been handling Mrs. C.'s affairs had died. The brother's death left this responsibility to the patient's sister, who not only had a dying husband but had resented Ms. C. for having been treated as a "princess" throughout her life. Our team's provision of a forum for the expression of feelings, clarification of roles, and discussion of possible social services helped to relieve the family's burden and tension so that Ms. C. could remain in her home.

As evident in the above example, clarification of lines of responsibility was an important task in situations where role confusion and strain were apparent. Cases were referred to the Outreach team because "something should be done" but who should, or who wanted to, do it was not clear. If disgruntled landlords or relatives wanted to resolve tension by handing over responsibility to our team, the actual capacity of the older person to function independently had to be assessed and our team's limitations had to be clarified. In some instances, by avoiding pressure to take over, tension was reduced because persons who referred patients felt that they had a second opinion and had done what they could. A small shift in some part of the patient's biopsychosocial system often served to stabilize a precarious situation.

Finally, health professionals and other interested parties who referred patients to the team sometimes saw the situation of the older person more negatively than did the older patient him/herself.

Ms. L., a 74-year-old woman with dementia, lived alone but was cared for by two neighboring alcoholics who brought her food daily. The social worker was concerned about this arrangement, but Ms. L. seemed comfortable with it. Although it was possible that some money was being skimmed off the top by her associates, she liked their attention and they were performing a needed service for her. State guardianship was initiated, but it was recommended that Ms. L. remain living in the same apartment.

A larger percentage of elderly patients in the "Stable" category showed difficulty with self-care, creating tension between themselves and their environment. Compared to the "Improved" cases, active therapeutic intervention or change occurred less frequently in the stabilized group. The offer of support, initiation of guardianship, increase of social services, and clarification of roles tended to stabilize previously precarious situations.

Unimproved Cases

The 18 patients in this group were referred more frequently for conflictual relationships (61%), bizarre or disruptive behavior (44%), and problems related to excessive dependency (28%). Affective disorders (44%) and paranoid disorders (33%) were the most common primary and secondary diagnoses. In general, this group exhibited more longstanding character pathology, more dependency, and more acute medical problems. Unimproved patients and their families more frequently refused or ignored treatment recommendations than did those in the other two outcome groups.

Careful review of the history and treatment experience of the unimproved patients revealed two distinct patterns. One subgroup consisted of patients referred because of bizarre behavior and problems in self-care. Because of marked suspiciousness, paranoid delusions, or denial, the team's help was refused. Family and outside social support was usually minimal or non-existent. Although guardianship and other interventions might provide some relief, these patients were more resistant to help and more troublesome to others; consequently, tension between them and their environment persisted. For example, one woman was engaged in court battles with her landlord. Another would not pay rent because she "rightfully" owned the Chicago Housing Authority senior citizen buildings. A third patient moved from apartment to apartment to avoid persecutory landlords. The tendency for these delusional patients to act out on their environment or raise serious public health problems led to continuing conflict with the people around them.

The second subgroup of "Unimproved" patients was embroiled in intensely ambivalent relationships. Such relationships might involve a mother and daughter, a husband and wife, or a caretaker and patient. These older patients were invariably described by significant others as "manipulative," a "bottomless pit," or "intensely dependent." Despite apparent emotional pain, the responsible others were often unable to directly accept therapy for themselves. Indeed, it seemed that their expectations of the team were implicit and unrealistic. They seemed to hope that the older person would be cured or controlled through magic, intimidation, or legal commitment. A representative case of this type is described below.

Ms. T., a 74-year-old woman, was living alone in a disheveled house where she had resided for more than 30 years. Since falling a year ago, she wrote frequent letters to her youngest daughter in Georgia requesting that the daughter move in and take care of her. While visiting her mother, the daughter called the team, whispering on the telephone that something had to be done as the situation between her and her mother had been terrible and was growing worse daily. She hoped that the team would either persuade her mother to go to a nursing home or commit her. During the team's visit, Ms. T. was guarded but insisted that, despite her fall, she wanted neither to move nor to receive outside help; she seemed capable of caring for herself with the little support that she received from her daughter and she was not commitable. Ms. T.'s daughter did not want to initiate guardianship proceedings and finally returned to Georgia after she felt reassured that she had done all that she could for the present. She resisted the team's suggestions to enlist the help of other family members.

Paradoxically, "Unimproved" cases required considerable attention by the team as well as other professionals, yet change seemed minimal. Recommendations for therapy, aimed at resolving conflictual issues, were either refused or abruptly terminated. The patient and his/her responsible others appeared to be trapped in a deadlocked family system, and the team similarly felt frustrated and impotent. In summary, these cases presented longstanding severe personality and interpersonal problems which had become intensified by recent stress or illness. The team's recommendations were usually not accepted.

Conclusion

The Geropsychiatric Outreach Team was developed in order to evaluate and treat emotionally and cognitively impaired elderly persons in the natural setting of their homes.

Information available on 66 of the first 83 patients reassessed at the 3-month followup indicated that 73% of the 66 patients showed evidence of improvement or stabilization. Particularly striking was the finding that 50% of the cases with a primary or secondary diagnosis of dementia showed improvement in the patients' level of confusion, dysphoric mood, or interpersonal tensions. The improvement rate among these patients contrasts markedly with the therapeutic nihilism and pessimism often associated with the treatment of cognitively impaired elderly patients.

Older persons with persecutory delusions were a subgroup of patients who also presented problems in the community. Although some of them refused any contact with the team, others were able to benefit from medication, hospitalization, guardianship, or the gradual non-intrusive development of a therapeutic relationship.

The openness of the patient and/or significant others to actively collaborate with the team correlated highly with improvement or stabilization. In the "Unimproved" group, significant others often had unrealistic expectations of the team and did not follow our recommendations. The "Unimproved" group also had a greater incidence of character pathology, longstanding conflicted interpersonal relationships, and severe medical problems.

Even though most patients had a considerable number of physical, social and psychiatric problems, 86% of the 66 patients assessed at the 3-month follow-up were still at home. When nursing home placement was necessary, it most typically followed hospitalization and occurred when excessive dependency, anxiety, or physical disability was coupled with lack of social resources; the experience of ISPI's Geropsychiatric Outreach Program, however, suggests that permanent institutionalization was neither the necessary nor the inevitable outcome for the majority of our patients.

The team offered a wide range of services. Its capacity to provide direct and immediate service, particularly in situations requiring guardianship a hospitalization, was important in areas of the co munity where alternative resources were not read available. In addition to direct service to the old person, psychiatric expertise was readily available relatives, friends, and professionals who we attempting to manage confusing and difficult situ tions. The team's consultative function seem particularly valuable as it provided a timely seco opinion based on our personal experience with ea older patient. Agency staff, family members, or a quaintances could often provide ongoing support the older person, and the team was able to work w them to develop a framework for intervention bas on a professional understanding of the older p son's emotional and physical needs. From the resu of this study, we believe that home evaluation a treatment of the psychiatrically impaired elderly c be instrumental in alleviating suffering and in prov ing a viable alternative to hospitalization and lor term institutionalization.

References

American Psychiatric Association (1980). *Diagnostic and statistical manu mental disorders* (3rd ed.). Washington, DC: Author.

Kahn, R., Goldfarb, A., Potack, M., & Peck, A. (1960). Brief objective m sures for the determination of mental status in the aged. *Amer Journal of Psychiatry, 117,* 326–328.

Kahn, R., & Tc in, S. (1981). Community measures for aged persons altered brain functions. In Nancy E. Miller & B. Cohen (Eds.), *Clin aspects of Alzheimer's Disease & senile dementia. Aging, Vol. 15.* York: Raven Press.

Raskind, M., Alvarez, C., Petrzyk, M., Westerlund, K., & Herlin, S. (19 Helping the elderly psychiatric patient in crisis. *Geriatrics, 32,* 51–

Reifler, B., Kethleu, A., O'Neill, P., Hanley, R., Lewis, S., & Stenchever (1982). Five-year experience of a community outreach program for elderly. *American Journal of Psychiatry, 139,* 220–223.

Salen, B., & Gold, C. (1980). The late life counselors service: A program the elderly. *Hospital and Community Psychiatry, 31,* 403–406.

The 1985 International Congress of Gerontology

The International Association of Gerontology

The XIII International Congress of Gerontology
will be held at
The New York Hilton Hotel
New York City, USA
Friday, July 12 through
Wednesday, July 17, 1985

The program will include sections devoted to Medicine, Biology, Behavioral & Social Sciences, Social Research, Planning & Practice.

Make Your Plans Now!
Watch for Call for Papers early in 1984.

Host Societies: The American Geriatrics Society
The Canadian Association of Gerontology
(Association Canadienne de Gerontologie)
The Gerontological Society of America

BLANK PAGE

CHAPTER 5

Psychopathology and Behavioral Assessment

OLDER PERSONS MAY MANIFEST many types of psychological disorder, ranging from the minimally impairing to those problems that severely alter the person's competencies. Three cases illustrate the diversity of presenting symptoms of the aged. Miss A. is a quiet, retired professional, aged 68, who came to an outpatient clinic because of loneliness. She felt isolated from other persons and had few activities or interests that stimulated her or utilized her talents. Mrs. C., also 68, wanted someone to intercede with her landlord, whom she claimed had been causing her apartment to shake and to be filled with unpleasant smells. She was currently sleeping in the bus station and reported that she had had similar problems in the last 4 places she had lived. Mr. K., a 60-year-old retired engineer, complained of memory problems. He had retired early from his job after developing Parkinson's disease. Although he had little functional impairment from his illness, he spent his days engaging in few activities. He stated that he watched daytime television programs, and was then unable to remember what had just happened. He also said he did not pay much attention to what he was watching.

The professional has to make similar decisions for each of these cases. First, it must be determined whether a problem is present that warrants treatment. Loneliness, for example, is experienced by most persons at some times in their lives, and the question can be raised whether special mental health treatment is necessary. If, on the other hand, we should provide psychological treatment to someone who is lonely, then how much loneliness should be present before we make an intervention? Second, it is necessary to clarify and delineate what type of problem or problems a

Statistical Manual of the American Psychiatric Association, or DSM III (1978), is one outcome of this process. The focus of treatment has often been on curing the hypothesized disease entity, rather than responding to the presenting symptoms.

Psychoanalytic models of diagnosis and treatment form an important variant of the medical model. Rather than viewing the causes of disorders as medical illnesses, however, psychodynamic theories stress the importance of early psychological experiences as the roots of symptoms manifested in adulthood. Similar to the medical model, psychoanalytic writers have emphasized that symptoms reflect an underlying illness, and that one must treat the deep-seated conflict that lies at the core of the symptoms (Nathan and Harris 1975).

Development of the medical model for the diagnosis and treatment of mental disorders has led to several major advances. Among these are a general humanization of care for persons with mental problems, the identification and treatment of specific disorders that have an organic basis, such as the mental symptoms associated with syphilis, and the development of psychotropic drugs that can assist substantially in the treatment of particular problems. The recent discovery of the relation of manic-depressive psychoses to imbalances in the salt lithium carbonate made it possible to attenuate the drastic mood swings that characterize this disorder (Foster, Gershell, and Goldfarb 1977).

In terms of older persons, the medical model provides an appropriate framework for conceptualizing some common psychiatric problems. Principle among these are the brain disorders, which are caused by structural damage or by various physiological disturbances that lead to altered brain functioning. Similarly, the study of stress reactions of the elderly may lead to major advances in treatment of mental disorders. It has been proposed, for example, that older persons have altered or impaired responses to stress (Marx 1974a). The development of ways of bolstering or augmenting stress reactions of the aged can provide important steps in the prevention of some mental disorders.

The medical model also has critical problems that limit its extension to all psychological disorders, including those of the elderly, First, at a very basic level, it provides an inaccurate conceptualization for the majority of psychological disturbances. Most emotional or behavioral problems do not result from similar etiological factors as do physical illnesses, such as tissue damage, viruses, or organ dysfunction. It would appear, rather, that mental disorders are related to continuous adverse or stressful influences that individuals are exposed to over long periods of time, and to persons and other environmental influences in an individual's life (Zax and Cowen 1976). Second, it has not been possible to develop a reliable diagnostic system based on the medical model. There has been no agreement on what symptoms are necessary for the diagnosis of hypothesized

underlying disorders for many types of mental problem. It is not clear, for example, how much depressed affect a patient must have before one can make a diagnosis of one of the affective disorders, and attempts to obtain reliabilities in diagnosis have often failed. Furthermore, many of the diagnostic labels commonly used are not related to specific treatment procedures and have limited predictive value (Nathan and Harris 1975). A further assumption that similar symptoms reflect a single underlying etiology can also be questioned. In elderly patients, for example, paranoid delusions and hallucinations may be indicators of several distinct problems, including acute or chronic organic brain syndromes, chronic paranoid schizophrenia, a hearing disorder, or a response to increasing social isolation (Berger and Zarit 1978).

The medical model also makes assumptions about the process of treatment, but procedures that are effective in dealing with acute medical problems are not appropriate for most behavior disorders. This viewpoint has been elaborated by Thoresen and his associates (in press), who write:

> A person experiencing bacterial pneumonia can be given powerful antibiotics. These drugs will usually be effective regardless of the person's knowledge of their mechanisms of action. Further, these drugs do not require the person's active involvement other than to comply to the prescribed regime for taking the medication. . . . A change in behavior can seldom be achieved by means of an automatic effect produced by any treatment technique. Instead, meaningful change which is maintained requires persons to possess a variety of skills for assessing and managing a myriad of environmental and cognitive events. . . .

Thus the treatment of psychological disorders involves the active attempts of clients or patients to change some aspects of their behaviors or thoughts, and represents a different sort of process from the usual exchange between doctor and patient.

A major problem of the medical and psychodynamic models of psychopathology is their emphasis that disordered behaviors emanate from within the individual. This assumption has two important consequences. First, by looking for the cause of maladaptive behaviors or emotions within the individual, one can miss critical interpersonal and other environmental events that have a profound influence on dysfunctional behaviors (Rimm and Masters 1974; McLemore and Benjamin 1979). A person who complains of depression, for example, may receive attention from her spouse only when she talks of feeling sad or upset, while at other times he will interact little with her. Over the years there has been impressive evidence of the influence of environmental factors on all sorts of behavioral and affective responses. Even for persons with organic disorders, that is, problems that derive from structural damage to the brain, the environment continues to influence actions and feelings. Any conceptual

Presumably the feelings of persecution reported by the second client represent a different sort of phenomenon from either loneliness or the subjective complaints of poor memory, and should be treated with procedures specific to that kind of disorder.

The ways in which the practitioner deals with these basic circumstances are influenced by two factors: (1) one's concepts concerning the nature of psychopathology; and (2) the means of assessment used to determine whether a problem is present. Our conceptual framework or model of psychopathology is critical because it influences whether we perceive that a person has a problem. How we formulate that problem also influences our judgment about whether treatment is likely to be effective and what type of treatment to use.

To cite an example of how concepts of psychopathology affect these decisions, 2 extreme positions can be contrasted: the "aging as pathology" and "aging as social pathology" models of dysfunction. Briefly, the "aging as pathology" model views the aging process as leading inevitably to deterioration of basic physiological and psychological functions. This perspective considers the behavioral or emotional problems of an older person as a normal concomitant of the aging process. A corollary to this position is that since no effective means exist for slowing or reversing the phenomena of biological aging, custodial care is the most appropriate intervention. While stated in an extreme form, this model is held implicitly both by many of the lay public and by professionals who interact with the aged, and results in an excessive use of custodial and other inappropriate treatments (Kahn 1975). In contrast, the "aging as social pathology" model suggests that the problems of the aged derive from the age discrimination and economic disadvantages to which older persons are subjected. Some professionals, for example, have claimed that the intellectual deficits associated with senile dementia are produced not by an underlying brain pathology but because of a lack of social stimulation and of relevant social involvements for older persons. Someone working within this framework would not be concerned with the issue of differential diagnosis of organic and functional conditions, but would treat all complaints of the aged as manifestations of the losses of status and role that often accompany aging in our society. While these models represent extreme views, they serve to illustrate how our ideas about the nature of psychopathology in the aged influence clinical decisions.

The means of assessment we use are also dictated by our beliefs about the nature of psychopathology. If one views the brain disorders of later life as distinct in their etiology from other types of behavioral problem, then it is necessary to develop procedures for making differential diagnoses. Someone, however, who feels that all problems of the aged are rooted in

different if depression is seen as the result of an underlying and unconscious conflict or as the consequence of poor social and other behavioral skills necessary for obtaining positive reinforcements from the environment.

Our knowledge of the causes of and cures for mental disorders of persons of any age is often quite limited. This is particularly the case when considering the problems of older persons, which have only recently been studied in systematic ways. At the present time there is no agreed-upon and empirically based framework for conceptualizing the psychopathologies of old age. In the present chapter several models of psychopathology and their application to the problems of old age will be reviewed. From these models a framework will be proposed for the psychological assessment of older persons. The evaluation of brain disorders and physical assessment are discussed in subsequent chapters.

Models of Psychopathology

THE MEDICAL MODEL

The medical model is the most widely held conceptualization of psychopathology. The very terms used to refer to problems in behaviors or emotions are derived from this model. Thus we speak of mental health or illness and, as in medical care, have emphasized one-to-one treatment between doctor and patient as the preferred means of therapy.

The medical model was developed in the nineteenth century to extend the growing field of scientific medicine and research to mental disorders. Prior to that time, different conceptualizations were held. In the middle ages it was believed that mental disorders were the result of possession by demons or witchcraft. During the Age of Enlightenment, mental patients were seen as having been exposed to morally corrupting influences (Nathan and Harris 1975). The development of large state mental hospitals in the nineteenth century was in part motivated by the notion that mental disabilities might be cured by moving the individual to a healthful, rural environment. As a medical orientation developed in the mid- to late 1800s, major discoveries of the causes of mental disorders were expected that would be similar to the advances in the care of infectious diseases.

The medical model implies that various mental and emotional disturbances are due to structural damage to body organs, especially the brain, or to altered physiological processes, such as in disorders of metabolism or endocrine function. Just as the symptoms of fever, headache, and mild nausea are often caused by a viral agent, it is hypothesized that mental symptoms are also due to an underlying illness. This assumption

BLANK PAGE

quests for information are dismissed as due to the person's age. In the legal systems of various states, someone can be denied legal rights over property or person solely on the criterion of being old, without any test of competency. Thus the medical model creates the expectation that anything a person with a mental problem does is a sign of that "illness," particularly for older persons whose problems are perceived as due to an inner pathological state of "old age."

To what extent is the process of biological aging implicated in the development of behavioral problems of the aged? The answer cannot be estimated with a great deal of certainty, but it is likely that the biological changes that accompany the normal aging process contribute in varying degrees to the onset of behavioral and affective symptoms. The most direct relation is between somatic illness and psychiatric symptoms. As people grow older, there is an increased prevalence of a variety of chronic illnesses, which directly or indirectly affect mental functioning. As an example of an illness with a direct impact on behavior, the senile brain diseases become increasingly prevalent at advanced ages (Kay 1972). Many other chronic illnesses affect psychological functioning in indirect ways. Diseases such as diabetes, arthritis, or cardiovascular disease often place limitations on an individual's mobility or the performance of particular activities. These restrictions, coupled with the distress involved in many chronic ailments, can have a great impact on the person's mental state. As will be discussed in Chapter 8, illnesses are a major precipitant of depression in the elderly.

It has also been proposed that the aging process involves changes in an organism's ability to respond to stress. In studies of young persons the occurrence of stressful life events is associated with higher rates of somatic illness (Rahe 1974) and with greater psychiatric symptomatology, especially depression (Paykel 1975). A stress model of aging would predict that the aged are even more vulnerable to the effects of stressful life events than are the young. There is, however, no empirical evidence for evaluating this hypothesis. In looking at the impact of life events on psychological functioning, Neugarten (1972) has proposed that the aged may, in fact, be better able than younger persons to adapt to various stresses. She has suggested that life events such as widowhood or retirement need to be viewed from a developmental perspective as "on time" or "off-time" in the life cycle. An on-time event is one that occurs at an expected or average time. The consequence of its being on-time is that the individual is likely to have made some preparation for the event and to receive greater support from his social network. Using widowhood as an example, Neugarten would argue that an older woman is more likely than a younger one to have anticipated becoming a widow. She may have made more preparations for that event and would be more likely to know other widows from whom she could draw support.

Another critical variable in adaptation to stress is the magnitude of the stressful events. In studies of adaptation to illness, it has been found that older persons with mild to moderate degrees of cardiovascular or cerebrovascular disease react differently from younger patients. While the young who are affected to the same extent are likely to deny their illness, older persons were generally depressed. Among those persons whose physical deterioration was more severe, however, older patients were likely to have greater psychological impairments, particularly in the manifestation of extensive denial of illness (Goodman 1972; Zarit and Kahn 1974). Similarly, Lowenthal and her associates (Lowenthal, Berkmen, and associates 1967) reported that life events such as illness, retirement, or widowhood were not related to psychopathology when only one such event has occurred in the recent past. When cumulative stresses were experienced, there was an association with impaired psychological functioning.

One further point about the relation of stress and aging should be considered. In studies of humans, chronological age is used as an index of aging. As was discussed in Chapter 2, individuals vary in the rate and extent to which biological changes associated with aging occur. Thus, rather than assuming all 65-year-olds or all 75-year-olds have similar reactions to stressful events, it is more likely that aged persons will have varied reactions to stresses, depending upon how much age decrements are present for each individual. We often make too many assumptions about a person's functioning based on chronological age, when the critical variable is actually the presence or absence of specific age changes in the various physiological systems of the body.

Aging, then, cannot be assumed to have a straightforward relation to psychopathology. Chronological age has considerable social significance, but does not necessarily indicate the presence of an underlying illness or impairment that compromises psychological functioning. Similarly, stressful events may have a greater impact on the aged than on the young, but the effects of these events may be tempered by the amount of anticipatory socialization that has preceded their occurrence as well as by the severity of the stressor. It is tempting but often incorrect to assume that mental disturbances of the aged are due to old age.

Overall, the medical model for psychopathology has its uses and limitations for the problems of the elderly. It serves to call attention to disorders that have an organic basis, and focuses on somatic therapies, such as medications that sometimes have major benefits for persons with mental problems. In the absence of a clear-cut medical diagnosis, however, the tendency to view the person's problem as derived from some hypothetical internal disorder leads to an inability to differentiate normal from abnormal behavior. Because of the tendency to view old persons as impaired due to their age, excessive use of the medical model and its variants reinforces the likelihood that one will blame a problem on something inside model of psychopathology must systematically incorporate these environmental factors into its diagnostic and treatment procedures.

Another consequence of viewing disordered behavior as due principally to an internal psychological or medical defect is that behaviors and emotions are not evaluated for their own sake, but only for how they might be signs of a more basic illness. As a result, assessment takes the form of trying to fit a patient's observable actions or statements to a hypothesized syndrome or disease. Once a diagnosis is made, however tentative, there is a tendency to look for confirming signs of pathology in everything a person says or does. Because any behavior can sometimes reflect pathology within this framework, it is difficult to find agreement on consistent diagnostic criteria.

A study by Rosenhan (1972) illustrates how difficult it is to differentiate normal from abnormal behavior using this illness model. Persons who were functioning adequately in their everyday lives presented themselves for admission to various mental hospitals, including both public and private institutions. These "pseudopatients" were instructed to state to the admitting unit that they were hearing voices that whispered to them the words "empty," "hollow," and "thud." Rosenhan characterized the symptom as indicating "existential psychosis," of which no recorded cases have ever been presented. Despite the vagueness of the symptoms, all the pseudopatients were admitted to inpatient units. Upon admission they dropped all pretext of having symptoms, but were still not discovered by the staffs, although in some instances other patients felt they were reporters or investigators. In retrospect, Rosenhan (1972) argues that the reason these pseudopatients were not discovered is the vagueness of the diagnostic labels used. Because mental patients are presumed to have some disease inside of them that affects their behavior in nonspecific ways, anything they do or say can be interpreted as pathological. As examples of this process, the pseudopatients observed that such normal actions as writing and standing in line early for lunch were noted by staff as signs of inner conflicts. In any disagreements between patient and staff the patient was typically regarded as wrong, because he was "mentally ill." Even straightforward requests for information or directions would sometimes be ignored by hospital personnel. If a patient then became angry over not receiving an answer, his response would be taken as indicating a mental problem. Thus the diagnostic labels that are used lead to a self-fulfilling prophecy, where normal and appropriate behaviors are misperceived as signs of mental illness.

Another problem is the tendency to perceive mental illness as a global impairment, affecting everything the person does, rather than as related to specific contexts or actions. Except for those with the most profound disorders, persons with behavior problems are capable of functioning in

mental disorder is not generally deviant in everything he says or does, but problems may be pronounced at particular times or in certain situations. This theme is emphasized in the movie *King of Hearts*, which shows the mental patients in a small French town during World War I living in relative harmony, while 2 competing armies slaughter one another. While this is a romantic view, it does make the valid point that having a mental illness does not mean a person is incapable of exercising judgment or of functioning adequately all the time or in all circumstances.

AGING AS ILLNESS—A VARIANT OF THE MEDICAL MODEL

An overreliance on the medical model can lead to similar problems in the aged. There is a tendency to see any problem of older persons as due to a vaguely defined internal disorder—the aging process. Aging is incorrectly perceived by many persons as involving a gradual deterioration in functioning in all areas. Thus, whenever an older person does anything that is strange, out of the ordinary, or disturbing to others, this "misbehavior" may be perceived as due to old age. Just as the ordinary actions of the pseudopatients were seen as signs of mental illness, behaviors of the old are sometimes inappropriately labeled "senile" or "senescent."

As an example of this inappropriate labeling, a 73-year-old client of a geriatric day-treatment program was brought up for evaluation at a staff conference. Two members of the staff insisted Miss G. was senile, because she was unable to knit and because one member of the staff observed her become flustered at the bank when she was unable to find her checkbook in her purse. While these behaviors can certainly be manifested by persons with organic brain disease, they are also shown by normally functioning individuals. Miss G. was, in fact, tested for the presence of characteristics associated with senile brain disease, including persistent forgetfulness, and was found to have no noticeable memory or learning problems. The complaints of the staff made sense, however, in another way. Miss G. had never knit in her life and, moreover, had severely restricted vision in both eyes because of cataracts and glaucoma that undoubtedly made it difficult for her to learn to knit. Furthermore, she was a difficult person to get along with, often interfering with the staff when they interacted with other clients, or suggesting she knew how to manage the program better than the staff did. She had worked her whole life in preschool education and had extensive experience in an activities-oriented program. The staff members were obviously quite upset because of her interference, but because she was old they attributed the problem to "senility" and "old age."

Many other examples can be given to illustrate this tendency to view the behaviors of the old as being derived from a vaguely defined inner pathological state called "old age." Older persons are often viewed by physicians as "crocks," and even the most appropriate complaints or re-problems presented by a patient and other behaviors. Depressed persons, for example, generally report their low spirits as the principal problem, but recent work has found that depression is related to certain dysfunctional thoughts that lead to overly negative evaluations of one's self (Beck 1976), and to the failure to engage in activities that one finds pleasurable (Lewinsohn, Biglan, and Zeiss 1976). This process of identifying functional associations among thoughts, behaviors, and mood represents a different process from inferring a disease from overt symptoms.

This type of approach contrasts sharply with the psychodynamic by identifying dimensions in the person's immediate situation, rather than the distant past, that trigger or reinforce problem behaviors and affect. While it has been argued that treatment will be ineffective if it focuses only on presenting symptoms and leaves the core of the problem unresolved, there is little empirical evidence of phenomena such as symptom substitution that are predicted by psychodynamic theorists (Rimm and Masters 1974).

The focus of a behavioral model is on the specific problems presented by clients, rather than on trying to infer a single etiology or syndrome of which those symptoms are a sign. Treatment proceeds by dealing with problems one at a time with an appropriate intervention, rather than by taking a global approach through which it is hoped that some of the exchanges between client and psychotherapist will generalize to everyday situations. There is also more stress on giving clients tasks to perform or homework, since psychological problems are conceived as related to specific environmental contexts.

A behavioral approach, then, investigates the context in which problem behaviors occur, and identifies those factors in the immediate environment or in the person's prior learning that can lead to changing the problem behavior. Behavioral methods can be used in a complementary fashion to the medical model. In cases where an organic basis for a disorder can be ruled out, then a behavioral assessment would be the next step in diagnosis. When an organic disorder is present, however, the first step would be to employ whatever relevant medical interventions are necessary. As a subsidiary aspect of treatment for organic disorders, behavioral assessment may be useful for identifying ways of modifying specific problem behaviors.

OTHER MODELS

Four other models of psychopathology have relevance for viewing problems of the aged.

Legal. Legal criteria are important because they set broad guidelines for how practice in the mental health field may be conducted. While specific guidelines may vary somewhat from one state to another, persons are usually judged as requiring care if they are a danger to themselves or to others. This criterion thus applies only to the most severely disturbed patients. In situations where someone refuses treatment or denies problems that others complain about, that person can be compelled to accept help only if it is demonstrated in the manner prescribed by state law that he requires involuntary treatment.

In most cases, treatment must involve the active consent of the individual. This principle is particularly important in dealing with the aged. Persons other than the aged individual, such as neighbors or children, often seek treatment on his behalf. In many of these situations the older person has some problems, such as a limited ability to care for a household or declining interest in social activities. But unless these abilities for self-care are so severely reduced that the individual meets legal criteria for needing treatment, interventions cannot be made without consent. All too often older persons are relocated or other major changes made in their lives without their active approval. While it is upsetting to professionals and families to see persons refuse treatment that could help them substantially, anyone who functions within the broad legal definition of competency has the right to make that decision.

Humanistic. Another model of psychopathology is drawn from humanistic psychology. This approach stresses that the individual has a natural tendency to strive for growth and development, or what has been called self-actualization. (Rogers 1951; Maslow 1968). Clients often have an ideal view of how they would like to be functioning. Neurotic behavior has been found to be associated with a discrepancy between how the person would like to be and how he sees himself as actually functioning (Rogers and Dymond 1954). This discrepancy is often a key to identifying problems and goals for treatment. Some older clients have difficulty imagining how they would like their lives to be different; meaningful treatment objectives can be set by helping them to articulate their ideas. Another major contribution of this model is its emphasis on the worth and dignity of the individual. Accent is placed on seeing the world from the client's perspective. The therapist does not play an authority figure but, instead, shows genuine emotions during treatment sessions, especially warmth and nonpossessive caring.

While this approach has made many positive contributions, there is a tendency similar to the medical model to confuse normal and abnormal behavior. Because the goal of treatment is often stated as helping the person achieve optimal functioning, everything short of optimal functioning can be viewed as a problem. An almost romantic quality exists in the writings of many humanistic therapists that posits striving for a conflict-free, higher order of consciousness.

As in the case of the medical model, this type of formulation makes it difficult for therapists to distinguish between problem behaviors and the person and miss those factors in the individual's environment that are influencing or controlling the disturbed behavior.

A Behavioral Model

A behavioral model proposes that problem or maladaptive behaviors are governed by similar principles of learning as are other actions. Rather than looking for a hypothesized underlying etiology, as in the medical model, a behavioral approach focuses on the specific maladaptive actions, thoughts, or emotions, and the contexts in which they occur. Treatment is conceived as providing new learning that competes with the maladaptive behaviors and/or manipulating stimulus cues or reinforcers that are related to the specific problems. From this perspective assessment involves clarifying the presenting problem, obtaining a social history that focuses on the origins of the problem behavior, and identifying relationships in the person's current environment that may be controlling or reinforcing the maladaptive behaviors.

Behavioral theories suggest several ways in which maladaptive mental disorders can develop. First, prior stressful experiences may have led to the association of anxiety or other inhibiting emotional reactions with specific actions. Because of this prior conditioning, the person's performance in certain situations is impaired. Second, an individual's earlier learning of some habit or skill may have been deficient or may not have taken place at all. There is often little direct socialization, for example, of the skills necessary for maintaining an intimate relationship. A person may have learned very little about how to reach compromises, or may have been taught specific habits that actually interfere with maintaining the relationship. (Perhaps the best example of where the absence of prior learning or faulty learning affects behavior involves sexual dysfunction.) Treatment programs such as those developed by Masters and Johnson (1970) emphasize teaching new habits that promote successful sexual functioning and replace the dysfunctional habits that had been learned earlier. Third, particular environmental stimuli may have come to be associated with maladaptive responses, and serve as cues that release those responses. As an example, many smokers have come to associate drinking coffee with having a cigarette. In trying to stop smoking, the person may feel the strongest urge to have a cigarette when drinking coffee or engaging in other behaviors that have become associated with smoking. Fourth, maladaptive behaviors may be currently reinforced. A person who is depressed may receive attention when complaining of his problems, but may not have much involvement with others on other occasions:

In recent years this direct behavioral approach has been extended to include cognitive dimensions. The major problem for some persons may not involve how well they function in various situations, but how they evaluate their performance. Two persons could carry out identical tasks, one judging his performance as adequate while the other sees his functioning as impaired. Feelings of depression have been linked to this kind of inaccurate evaluation of one's own performance. Similarly, certain beliefs that the person learned previously may lead to dysfunctional behaviors (Ellis 1962; Mahoney 1974). An individual who believes she must please everyone she comes in contact with may make excessive efforts to be liked and feel crushed if she does not receive approval from some persons. Thus beliefs about oneself, about others, and about the nature of social relationships may be intervening variables between perceptions and problem behaviors or emotional distress.

Another cognitive factor that has received attention recently is the person's problem-solving strategies. When faced with a task, people engage in an inner monologue. This inner voice plans for undertaking that task and monitors one's progress. These ways we have of talking to ourselves can be effective or ineffective for solving the problem at hand. Hyperactive children have been found to use few or inadequate strategies in approaching learning problems. Programs that teach these children to guide their actions with appropriate verbal comments have resulted in improved performance on cognitive tasks and in behavior (see Meichenbaum 1977). The person's inner monologue may therefore be an important mediator of behavior.

One advantage of a behavioral approach is that by focusing on the specific problems presented by clients and the contexts in which they occur, it is often possible to identify what factors in the person's environment are influencing them. These can then be manipulated to lead to improvement in the presenting symptoms.

Unlike the medical model, there is less difficulty in differentiating normal from abnormal behavior from a behavioral perspective. In the medical model the professional uses relatively unreliable criteria to determine if symptoms suggest an internal conflict or disorder. In contrast, a behavioral approach is not concerned with whether an illness is present. The focus is placed instead on the perception of problems in functioning by the individual or by persons closely associated with the client. The issue of what does and what does not constitute a problem is clarified, because the problem is defined as that for which the person seeks treatment. When a person is brought to treatment by others, the process of determining whether his behavior is a problem that warrants treatment is more complex. The process of assessment involves determining how each of the involved persons contributes to the problem situation. One may then formulate a treatment plan that includes all the relevant individuals, i.e., those persons who contribute to or participate in the problem. Ways of making this type of assessment are discussed later in the chapter.

A behavioral assessment may also indicate functional links those that do not require treatment. Because most people are not functioning at what might be called their potentials, either in interpersonal relationships, in work, or in other areas, there is always some room for further growth and improvement. That type of situation, however, is conceptually different from the person who experiences significant degrees of emotional distress and whose abilities to carry out basic, everyday activities are impaired to some extent. Clients do not have to be helped to their full potential in order to provide relief from major symptoms and life stresses.

Psychotherapy can also produce feelings of dependency in clients. Most people know someone who has been in and out of psychological treatment for several years and, though functioning adequately in many ways, feels the need for ongoing assistance. This tendency for dependencies to develop is exacerbated in some older persons. It is important, therefore, that there be clearly stated goals for therapy, and attempts not be made to solve every problem the person has. Delimited objectives minimize the risks of undermining the client's independence.

It can be argued that all psychotherapy involves some value judgment about how to function effectively. The humanistic model stresses worthwhile human aspirations, but, despite its client-centered orientation, the specific goals that are frequently stated, such as having complete honesty in relationships with others or insight into one's motives, are not shared universally. Furthermore, individuals function competently and effectively in many life situations without having personal insight. There is also increasing evidence that positive changes can occur in therapy without insight into one's motives (Rimm and Masters 1974). Thus while insight and personal growth are often desirable outcomes, they are not necessary conditions for a person to function competently.

Statistical. A statistical model of psychopathology also has some relevance for evaluating problems of the aged. In this approach problems are conceptualized as those behaviors or other events that deviate significantly from accepted community norms. The advantage of this approach over the medical model is that it makes the criteria for diagnosis of a problem consistent with how the problem is actually conceptualized. We judge behavior such as transvestitism maladaptive in our society because it is statistically rare, although in some cultures such activities are actually encouraged in some individuals. The statistical approach recognizes that unusual behaviors are likely to have unpleasant social consequences for individuals. Persons who dress, speak, or otherwise act in unusual ways are going to be avoided or attacked by others, depending on the situation. Their difference from others becomes a problem in functioning by adversely affecting social interactions.

The disadvantage of this approach is that there are no criteria for distinguishing nonconformity and social protest from problems that are harmful to the person or to others, or that the person wants to change. Homosexuality is a good example. While statistically deviant and often psychologically threatening to heterosexuals, homosexual behavior has not been found to be related to reduced competency or to poor psychological functioning, as has often been assumed. Once considered a "mental illness," homosexuality has recently been removed by the American Psychiatric Association from its list of disorders. If someone with a history of homosexual relationships requests help to increase his or her sexual feelings toward the opposite sex, that would be a valid basis for starting treatment, but without that active interest in treatment by the client, there can be no compulsion to make him abandon his homosexual orientation or to give up any other socially deviant but harmless actions. Thus behavior that differs from community norms may or may not be properly identified as a problem, depending on whether it affects the person's overall competency and whether the individual perceives it as a problem.

A statistical model of normal behavior has additional problems when applied to the aged. There is generally no agreement on what normal behavior is for older persons. Criteria of adequate functioning during the adult years often include competency in a work role, in interpersonal relationships, and sexually (Schaie and Schaie 1977). In old age, however, there is often little opportunity for or encouragement of any of those activities. Furthermore, as discussed in Chapter 3, no consensus exists on whether it is better to stay active or to disengage from activities as one grows older. Perhaps the best formulation of what is normal in old age is that there are increasing differences among individuals over the adult life span. These differences are due both to exposures to varying life experiences and to the differential rates at which biological aging processes affect each individual. What is normal in old age is an increased variability of functioning among persons.

One other drawback of this statistical approach is that many behaviors that are judged by others as bizarre or eccentric may actually be appropriate for that person's generation or culture. Because of the rapid pace of social change, many personal habits and behaviors that were acceptable 50 or 60 years ago are no longer encouraged. Furthermore, many elderly persons have a different cultural background from younger professionals. They are more likely to have been born in a foreign country, in a rural area, or a small town, while today's professionals are most likely American-born and from an urban or suburban area. A strict statistical approach to evaluating persons would obscure differences between problems that actually impair the person's ability to function effectively and those eccentricities that have no harmful consequences.

Social Deprivations. A fourth model of psychopathology is that social deprivations lead to disordered behavior. It has been proposed, for example, that factors such as the high stress of urban life or social class are associated with a greater incidence of psychopathology at all ages (see

Hollingshead and Redlich 1958; Srole et al. 1975). Particular emphasis is often placed on social isolation and loneliness as causes of mental disorders in the elderly. It a series of studies Lowenthal and her associates (Lowenthal 1964; 1965; Lowenthal, Berkman, and associates 1967; Lowenthal and Chiriboga 1973) found that extreme isolation in old age was associated with poor adaptation in some persons but not others. Individuals who had a lifelong history of social isolation often did well in old age, while those who had only marginal social ties during the adult years had serious problems in adjustment during old age, when their few social contacts were lost. Furthermore, among persons who have had major stresses or losses, such as widowhood or retirement, the presence of a confidant reduces the amount of distress that is experienced (Lowenthal and Haven 1968). Perlin and Butler (1963) report comparable findings. Older men whose life styles could be characterized as having always been isolated often adapt well to old age In analyzing these findings they speculate that the social expectations for maintaining intimate relationships are removed in the later years, and these men were perhaps no longer experiencing themselves as deviant or different from others in their cohort who were now also socially isolated.

Social isolation and psychopathology in the aged may both be the consequence of a more basic problem. Many chronic physical illnesses result in limitations in mobility and thereby also affect one's social interactions. In these instances both the illness and the resulting social isolation undoubtedly contribute to the development of behavioral problems.

Many authors have pointed out the effects of social deprivations on the quality of life of older persons. In a moving book on the problems of the aged, Curtin (1972) quotes one older women who describes old age as similar to a prison term, with no time off for good behavior. Despite the deprivations to which the elderly are exposed, however, many continue to function effectively. The relation of social deprivations to poor functioning is a complex one that depends on several factors, including the type and amount of stress, the person's prior history, and current social and psychological resources (Lowenthal and Chiriboga 1973). Stressors, like social isolation or other negative life experiences, can be described as creating the context in which maladaptive behaviors may develop in an older person, but should not be viewed as the sole determinant.

Assessment of Psychological Disorders

Assessment of elderly patients is the critical key in the development of effective mental health programs for the aged. Careless or uninformed diagnosis can lead to inadequate treatment of various problems. Persons with senile dementia may be considered as depressed, and vice versa. Or a person's problems may be attributed to age, without any attempt to find an environmental determinant. Assessments can also provide important information about the most effective ways of treating a particular client.

The assessment of psychopathology has traditionally emphasized identifying underlying syndromes suggested by the presenting symptoms. Classifying systems such as the DSM III are useful for outlining broad groups of disorders, such as psychotic versus neurotic or grouping together psychological problems in which mood is a factor. The DSM III also provides an overview of the variety of mental disorders. It is important, therefore, to have a good working knowledge of traditional diagnostic categories. This information can be found in texts on psychopathology (Nathan and Harris 1975; Zax and Cowan 1976).

In the criticisms of the medical model cited earlier, it was noted that current classifying systems of mental illness, such as the DSM III, use labels that are of little use in planning treatment. Most schools of psychotherapy do not differentiate their techniques to any great extent according to the psychiatric label. Dynamic therapists, for example, generally stress uncovering unconscious material, whatever the type of presenting problem, although some variations in approach for different disorders are described. The labels themselves, however, carry little information that is specific for treatment.

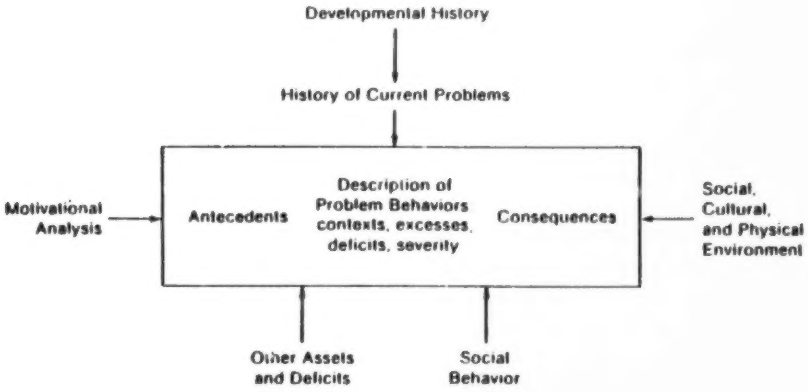
An alternative method for assessing psychological disorders is to get descriptions of the person's problems in as specific detail as possible. This should include the frequency of problem behaviors, in what circumstances they occur, and current reinforcers of behavior. By identifying the particular contexts in which problem behaviors are manifested, one can develop hypotheses concerning environmental or person variables that are associated with the problem behavior, and then intervene to change some aspects of the person-environment interaction.

THE FUNCTIONAL ASSESSMENT OF OLDER PERSONS

A thorough method of behavioral assessment that identifies factors relevant to treatment has been developed by Kanfer and Saslow (1965; 1976). While not specifically developed for older persons, this method of assessment provides a useful outline for gathering observations of the aged. In particular, it emphasizes the contexts in which problem behaviors occur. This approach identifies modifiable aspects of the situation, rather than attributing a patient's difficulties to old age, or to a characterological deficit about which nothing specific can be done.

In their system of functional behavioral analysis of psychiatric problems, Kanfer and Saslow suggest seven major areas: (1) analysis of the

FIGURE 5.1. Functional behavioral analysis of problems.


Developmental History
History of Current Problems
Motivational Analysis
Antecedents
Description of Problem Behaviors contexts, excesses, deficits, severity
Consequences
Social, Cultural, and Physical Environment
Other Assets and Deficits
Social Behavior

problem situation; (2) identifying antecedents and consequences of the problem behavior; (3) the individual's other assets and deficits; (4) an analysis of social relationships; (5) motivational analysis; (6) the relation of the patient to his social, cultural, and physical environment; and (7) a developmental history (see Figure 5.1). Each area will be discussed in some detail.

1. *Analysis of the Problem Situation.* The presenting problems of clients should be described as fully and specifically as possible. When one is confronted with difficult patients, there is a tendency to apply global labels to their problems. Calling patients hostile, aggressive, or confused, or describing them as passive or dependent personalities both presumes that the problems in functioning are determined by some internal state, and phrases the problem in terms that do not suggest treatment potential. Instead of labeling them, it is more useful to describe what it was that the patient did that made one feel he was hostile, dependent, or confused. The first step in a functional behavioral analysis is to describe fully what the problem behaviors are, considering for each problem its frequency, intensity, duration, and the situations in which it occurs.

Problems can be further classified as excesses or deficits of behaviors. This distinction calls attention to the fact that most maladaptive behaviors are normal actions that occur either too often or not enough, or at inappropriate times or situations. This process also serves to set clear and operational targets for treatment. As an example, the label "depression" includes persons with widely varying symptoms. Two common problems, however, are an excess of negative statements about one's self and deficits in social skill. One would determine the extent to which these specific aspects of depressive disorders are present in an individual case, and then develop a treatment plan that variously involves decreasing negative self-evaluations or increasing the person's level of social skills. Both approaches have been found to be related to significant reductions in reported depressed affect (see Beck 1976; Lewinsohn, Biglan, and Zeiss 1976). This type of assessment makes it possible to develop treatment goals and procedures that are specific to an individual, rather than based on abstract and somewhat arbitrary constructs such as depression or other classifications.

Problems involving excesses in behavior are usually readily apparent to observers, but deficits are sometimes harder to distinguish. To use the example of a depressed patient again, complaints of dysphoria are an obvious excessive behavior. It may not be noticed, however, that the person also has deficits in social skills that inhibit normal social functioning. In hospitals and nursing homes, the "good" patient who keeps to himself and is not troublesome sometimes surprises the staff with a sudden outburst or other disruption. In retrospect, it can be seen that his quiet, withdrawn, and nondemanding ways, which the staff labeled as "good," were actually deficits in behavior that led to increasing tension or frustration in his interactions with the environment. One should thus consider if there are some things a patient should be doing that he is not.

In describing the presenting problems, the severity of the maladaptive behaviors should also be considered. Gurland (1980) proposed five dimensions of severity: (1) the degree of distress subjectively experienced by the person; (2) the extent of impairment in performance of usual activities; (3) danger to one's self; (4) danger to others; and (5) the amount of burden on others.

One's estimate of severity is critical for clarifying several situations. First, persons with mild, transient problems may not warrant treatment. The danger of creating a dependency on a therapist or social agency can be greater in some cases than the risk involved in allowing persons to work out mild problems on their own. Second, some severe problems require prompt and intensive interventions. Particularly where a person's life or the lives of others are endangered, prompt actions, including legal steps if the person does not accept treatment voluntarily, are necessary. Third, where there is no clear danger and the person refuses treatment, the decision of the professional on what to do is more difficult. Despite the frustration or pain they cause to family members or others, some people may deny they have a problem. While they cannot be treated involuntarily, one can offer help and assistance to family members, so that they may become more effective in managing their interactions with these persons.

2. *Analysis of Antecedents and Consequences of the Problem Behavior.* Analysis of antecedents and consequences involves determining what happens immediately before the problem behavior and what are its main consequences or effects. Problems often occur only in specific situations or in

470

response to particular events, and can be considered under the control of those stimuli. Lewinsohn and his associates (Lewinsohn et al. 1978) classify antecedents of problem behavior or emotions into four types: (1) social settings (e.g., thinking pessimistic thoughts mainly when alone or with someone who is perceived as successful); (2) physical circumstances (e.g., being in the kitchen as an antecedent to between-meal snacks); (3) the behavior of others (e.g., reacting to mild criticism); and (4) one's own thoughts and feelings (e.g., feeling anxious or pessimistic before initiating a conversation).

By determining what factors are associated with the manifestation of problem behaviors, it is possible to pinpoint interventions to specific situations. People often report their problems as global, that is, affecting everything they feel or do, but this type of analysis highlights their more difficult interactions. Depressed persons, for example, typically say they feel depressed most of the time, but they can learn to identify specific antecedents of depression—those circumstances in which they feel more depressed. One man, for example, became depressed and anxious whenever he went for a doctor's appointment. These visits triggered feelings of helplessness, and also resentment at the doctor's authoritarian manner. By identifying an increase in depressive symptoms in this situation, it is possible to make an intervention in how the person thinks about the physical examination and how he interacts with the doctor, so that his thoughts and actions do not lead to depressive emotions. Even unusual and disturbing behaviors are under the control of specific environmental events. A person in a nursing home, for example, may exhibit bizarre behavior at times, with disturbances following interactions with particular staff members. One can then determine what occurs in those interactions that may be triggering the problem behavior. As opposed to labeling someone as confused or agitated, this approach leads to a direct intervention that will alter the problem behavior.

The consequences of a behavioral problem include factors that reinforce the problem. One consequence of paranoid behavior in the elderly is that it evokes a lot of attention. If an older person calls a family member and states that someone has broken into her apartment, it is likely to bring about a rapid and concerned response. Some common consequences of problem behaviors are increased interaction with others, receipt of other positive, tangible rewards, or allowing the person to avoid unpleasant situations. It is critical to identify these reinforcers of problem behavior, so that the treatment plan can include provision of these same reinforcements for appropriate behavior. For example, if a husband pays attention to his wife only when she cries, psychotherapy will not be successful until he interacts with her under other circumstances.

3. *Other Assets and Deficits in Functioning.* In addition to focusing on the problem behavior, one can determine what other positive qualities

the patient has, and what deficits are present in other areas of functioning. The consequences of problem behaviors are often illuminated by considering other deficits. When evaluating a person, it is possible to ask, "What would be different if you did not have this problem?" It sometimes becomes apparent that the individual has few skills or resources for becoming involved in satisfying activities. Because of these behavioral deficits, the person may actually have no other alternative than to continue behaving in the same ways, and no incentive to change. For persons with deficits in behavioral and social skills, effective treatment involves teaching those skills so that one's desired goals can be achieved through appropriate behaviors (See Meichenbaum 1976; Lewinsohn, Biglan, and Zeiss 1976).

Identifying behavioral assets also provides important information for developing a treatment plan. Many persons with severe behavioral problems in one area can function effectively in other parts of their daily life. One 65-year-old man, for example, who became depressed over health and family problems, had many interests and abilities, including regular exercise, active concertgoing, and many good friends. Because he was depressed, he had neglected some of these activities. When encouraged to resume them as part of the therapy, his mood improved rapidly. Identification of these areas of competence made it possible to increase their occurrence and thereby diminish the frequency with which problem behaviors were manifested. Knowledge of these assets in functioning can also be important to the therapy process in reducing negative self-evaluations made by clients and helping them place their current problems in a broader perspective, so that they do not come to see themselves as overly impaired or ill.

4. *Analysis of Social Relationships.* There should be a consideration of the person's social network, especially those persons who have an influence over or are affected by the problem behavior. It is then possible to determine the extent to which these persons should be involved in the treatment process.

An important aspect of the client's social relationships is identification of who has gotten the person to come for help, whether it is the individual himself or some other person. This issue is crucial in determining the focus of the treatment. In instances where family members or some other persons were principally responsible for an older person coming to treatment, one can raise the question of "Whose problem is it?" In many situations the older person will concur with those who brought him that he indeed has some difficulties in functioning and wants help. In some instances, however, determination of who has the problem is more complicated. When other persons complain about an older individual's behavior, but the "patient" does not view it as a problem, it is evaluated whether the actions in question raise any danger to the older person or to others. Persons will sometimes ask that an individual be treated for idiosyncratic actions that have no dangerous impact but are annoying. Older persons who keep many pets, whose yards are not maintained up to community standards, or who engage in mildly bizarre behaviors such as talking to themselves or believing in supernatural happenings may come to the attention of community service agencies because of complaints by neighbors or relatives. So long as they are able to take care of themselves and their homes meet minimal health standards, they cannot be judged as needing treatment. It is crucial not to label someone as mentally ill, solely because his actions violate acceptable middle-class standards of behavior. Somewhat disheveled or dirty households are not sufficient to warrant an intervention, unless it is desired by the person himself.

In situations where an individual's actions are disturbing to others, it can be pointed out that continuing these behaviors may have some bad consequences. One woman, for example, would stand outside her apartment, waving a Bible at neighbors and passersby in order to drive away the devil. Apart from annoying her neighbors, she was otherwise functioning well and had no problems in self-care. As part of a supportive treatment program for her, it was explained that the Bible waving might be misinterpreted by others, who would then try to have her hospitalized. She was encouraged instead to wave the Bible at persons from behind her door, a change she welcomed because she agreed that the Bible was powerful enough to work even through doors. While not directly treating her fears, this intervention prevented her situation from becoming worse.

Some brief counseling with neighbors may also be critical in situations like these. Their annoyances are often well justified, but there are sometimes ways of helping them to understand the situation so that they are less upset, or to allay some of their fears about what the "crazy person" might do. At the least, it is important to explain why the person is not being hospitalized. When family members are involved, some sessions with the older person and the family members can be useful to help work out a better understanding of the older person's behavior and to correct some of the family's misconceptions.

An important focus of the assessment should be the client's ideas about social relationships. An older person may feel that her children are taking advantage of her by asking her frequently to baby-sit for her grandchildren, but she does not want to tell them directly because she believes they should anticipate her needs. Or children may feel some actions of their parents, such as carrying on a romance, are inappropriate. People's ideas about social relationships that lead to passive or unassertive behavior are often associated with feelings of depression or helplessness. The most frequently encountered idea is that others should anticipate one's needs, without the person himself having to make them known. In some instances a client will have expectations about social relationships that are unrealistic or cannot possibly be fulfilled, given the usual patterns social

interactions take in the culture. One woman, for example, wanted to be included in every detail of her 30-year-old married son's life, an expectation that led to considerable conflict with her son and daughter-in-law. It was important to have her modify her ideas about social interactions in order to help her relate in more gratifying ways with her son.

5. *Motivational Analysis.* There should be a consideration of those persons, events, activities, or objects that are reinforcers for the patient, and also those events that are experienced as aversive or that the person avoids. This information will be useful in developing a behavioral therapy program for the patient.

A related consideration is the person's motivation for treatment. It should be determined what goals the person has for himself, and what he feels will be different about his life if he reaches those objectives. Through this approach it may be discovered that the individual does not really want to change but would like others to change in their reactions to him. Sometimes, too, a person is actually satisfied with his behavior but wants to change to please others or because of an abstract notion of what one is supposed to be like. An older person may come to treatment complaining of inactivity, for example, but will actually prefer leading a leisurely life. She may feel that she has to get active and involved with people or some terrible thing will happen. Some older persons incorrectly assume that senility is brought about by inactivity. When encountering this situation, it is appropriate to reformulate the problem as acceptance of what the person is already doing, rather than attempt to make any changes.

An important question to ask in an assessment is why a person decided to seek treatment at this time. When clients have been convinced to come by someone else, their motivation may not be high, making it necessary to engage their interest in working on their problems. It is probably better not to treat an unmotivated person with mild difficulties, than to create a situation in which he does not get better and may conclude that nothing can help. In some instances there may have been some change in a patient's circumstances that made him decide to come for help at this time. Identifying what has changed may help clarify the treatment goals. If a woman who has been depressed for some time seeks help because a close friend has recently moved away, a goal of treatment may be to help her develop a new relationship, or turn to other friends she relied on in the past.

6. *Analysis of the Social-Cultural-Physical Environment.* This assessment involves determining how well persons fit in with the expected norms for behavior and for the carrying out of tasks in their current environments. While the goal of treatment should not be to make persons adjust to their surroundings when they are unhappy about them, it is sometimes appropriate to help someone establish a better balance between personal needs and the demands of the environment. Some older persons

may be expected by others to fulfill demands for competence of role behavior that they can no longer meet or no longer want to meet. The wife of a retired man, for example, was concerned because he watched more television and was not as active as he had been in the past. He stated, however, that he had enough activities to keep him busy and he enjoyed taking things a little easier. More commonly, the aged receive little encouragement or expectation for competent behavior. They may even be expected to be passive and incompetent, leaving them feeling inadequate or depressed. It may be important to help some people to establish their own standards for how they want to act and to develop strategies for responding to the negative expectations of others.

A major area of concern for the aged is the ability to perform self-care activities. Being able to bathe, dress, shop, and cook enable a person to maintain an independent living arrangement. Major deficits in self-care result in the need for some form of assistance, either informally through family or neighbors or with the intervention of a social service agency. Assessment of these activities is discussed more fully in Chapter 7.

7. *Developmental Analysis.* A developmental history should be obtained on patients for 2 major reasons: to provide information about the person's usual functioning in the past, and for a history of the circumstances under which the particular problem or problems for which the person seeks treatment have developed. In dealing with the aged a developmental history is particularly useful. It gives the clinician an idea of what resources and abilities persons previously had, and how they handled stressful situations. Sometimes reminding persons of these abilities helps them spontaneously to use coping strategies that were effective for them in the past.

In obtaining a history of the presenting problem, it is important to identify any changes in the person's environment that were associated with altered behavior. Changes in health status and their consequences for the person's behavior and self-concept are also often pertinent. (The history of the problem is different from the investigation of antecedents and consequences of problem behavior. The former is concerned with when the problem behaviors were first manifested and what the circumstances were, while the latter looks at specific occurrences of the problem and what happened immediately before and after.)

From a developmental perspective it is possible to encounter three types of problem in the aged. First, some problems will have their origins in earlier periods of life. Persons with schizophrenic disorders, for example, often function at only marginal levels throughout their lives and have periodic episodes of disturbed behavior. Similarly, persons with affective disorders may have had similar episodes earlier in life. The importance of this information is that those treatments that were most effective in the person responded well to electroconvulsive therapy or to a particular medication, that can be tried again. Similarly, a positive response to a particular style of psychotherapy indicates that the person may show improvements now with the same treatment. Furthermore, these past experiences of improvements can be used to reassure patients that they will get better this time. This reassurance is particularly effective with severely depressed persons, and can be used to counter feelings of hopelessness and suicidal thoughts.

A second type of problem in the aged arises when behaviors of an individual that were adaptive earlier in the life cycle are no longer effective for obtaining personal goals or for sustaining a satisfying lifestyle. A person who works in a somewhat compulsive way, for example, may function well on the job that demands meticulous attention to detail. Upon retirement, however, that person's compulsive habits may no longer serve any purpose, and as a result he may begin manifesting some undesirable behaviors, such as excessive worrying or engaging in somewhat meaningless, repetitive actions that do not provide the satisfaction inherent in working.

A third type of problem in the aged occurs as a result of sudden changes in the person's environment, especially the occurrence of major losses. The person reacts to the losses by developing maladaptive behavior. Losses are associated with many of the behavioral disorders that first appear in old age, especially depression.

The history of the person's present problems also provides important information for making a differential diagnosis, for example, between senile dementia and depression or between acute as opposed to chronic brain disorders. The differing courses of those disorders are discussed in Chapter 6.

A NOTE ON PSYCHOLOGICAL TESTING

The use of psychological tests of personality with the aged has only a limited value. Most procedures that are commonly used have not been standardized for older persons or have only been used with impaired groups of elderly. Much of the literature on the Rorschach test, for example, looks at the responses of the institutionalized elderly, and then generalizes to suggest that these findings represent the way older persons respond to this test. Another limitation of most psychological tests is the assumption that they can be interpreted to reveal an underlying or true problem that is not apparent from direct observations of behavior or discussions with clients. Behaviors, including test-taking responses, are often specific to a situation and may not reliably predict an underlying trait or dynamic (Goldfried and Kent 1972). Tests have also been perceived as an objective validity, they are usually no more "objective" than any other type of information (Bersoff 1973). One further consideration is that the diagnostic interpretations of most psychological tests do not suggest appropriate treatments. In contrast to the functional behavioral analysis described above, which identifies relevant variables in the environment that are influencing problem behaviors, testing suggests vague diagnostic formulations but not differential treatment strategies.

The collection of systematic samples of behavior such as occurs in a test situation has many potential and valuable uses. These include conducting research on the effectiveness of treatments and developing more systematic ways to diagnose problems. Two reliable and structured interview procedures for mental health problems of the elderly are available—the OARs scale (Pfeiffer 1975b) and the CARE instrument (Gurland et al. 1976). The CARE in particular allows for a more systematic and objective approach to the diagnosis of behavioral problems in the elderly. As both instruments are lengthy, however, their practical applications are limited. Overall, then, while formal testing has some potential benefits, especially in the areas of program evaluation and outcome studies, existing tests either have limited value or are too cumbersome to apply in most clinical settings.

Summary

Psychopathology in later life can be viewed from several conceptual frameworks, including a medical approach, legal and social criteria, and a behavioral model. Each theoretical system contains assumptions about why disordered behavior occurs and has implications both for assessment and treatment. The usefulness of a particular model can be judged by whether dimensions relevant for treatment are identified. A medical approach is warranted in many cases because the older persons' problems are caused by or related to the effects of an illness. The majority of disorders in old age, however, have no obvious physiological correlates, and a behavioral analysis, which focuses on such factors as the frequency of occurrence and the antecedents and consequences of problem behaviors, is more likely to indicate treatable aspects of the situation. A behavioral method of assessment locates problems in the immediate situational contexts in which they occur, as well as evaluating the person's current social and psychological functioning and developmental history. A functional behavioral analysis is also appropriate in organic disorders to clarify what aspects of the person's situation or action are potentially modifiable.

JAGS 34:185–191, 1986

Age, Symptom Interpretation, and Health Behavior

Elaine A. Leventhal, MD, PhD, and Thomas R. Prohaska, PhD

The role of symptom perceptions and utilization of health promoting practices in illness behavior were explored across the adult lifespan. The first study (N = 396) assessed the health practices and perceptions about illnesses in well adults (ages 20 to 89) as well as perceptions about symptoms associated with a group of six specific illnesses. The second community study (N = 614) examined how symptom qualities (symptom severity, duration, and illness label) affect attributions of symptoms to aging and coping strategies in response to the symptoms. The findings revealed that while the elderly report more frequent performance of health promoting activities, perceptions about illnesses and how to prevent them are comparable across adulthood. Symptoms used to identify illnesses are also equivalent across adulthood (and aging) except for the reduced usage of mild ambiguous symptoms in identifying illnesses by the elderly. The frequency with which mild, short-term symptoms are attributed to aging increases with age of the subjects and leads to greater acceptance of the illness symptoms and more passive coping strategies. Clinical implications and policy recommendations are discussed. J Am Geriatr Soc 34:185–191, 1986

Our goal is to understand how the self-perception of aging influences the *commonsense* models of illness developed by older people and to investigate how these models impact on their medical and health practices.[1,2] In the first section of this paper, we briefly describe the conceptual formulation and results of two studies that investigated how age-related changes in commonsense models affected the health and illness behaviors in well persons. Specifically, we examined the extent to which changes in health behaviors such as taking vitamins, using over-the-counter medications, and visiting the doctor, were determined by age-related changes in the two primary components of commonsense illness models: 1) the perception and understanding of illness, ie, the way the illness is represented; and 2) strategies people use for coping with illness. In the second part, we spell out some of the clinical implications of both the formulation and findings.

Our model is based on two assumptions. We believe that health action, at all ages, is a function of the individual's commonsense model of disease, ie, his representation of the illness and the coping responses suggested by the representation. The representation has both cognitive and emotional components. The cognitive component consists of at least four different attributes: 1) symptoms and interpretation, ie, the label applied to the disease; 2) perceived causes of the disease; 3) expected consequences; and 4) anticipated duration (acute, cyclic, or chronic). The emotional component includes feelings such as fear, anger, depression, and shame.[1] Coping consists of at least three components: 1) the perception that specific responses are available for preventing, containing, or curing disease; 2) expectations of the effectiveness of these responses; and 3) belief in one's ability to perform these responses. The commonsense selection and execution of coping strategies is guided by the individual's representation of the disease, and also may be influenced by his emotional state.[2]

Second, we believe that at least some of the age-related changes in the frequency of health behaviors are determined by age-related changes in the factors making up the representation and coping processes. These assumptions shaped the design of our studies,

---

From the Departments of Psychology and Medicine, Clinical Science Center, University of Wisconsin–Madison, Madison, Wisconsin.

Presented as Illness Behavior in the Elderly (Howard Leventhal) at the 4th Symposium on Ethical and Clinical Problems in the Care of the Elderly, Madison, Wisconsin, November 1984.

Supported by grant AG03501 from the National Institute on Aging.

Address correspondence and reprint requests to Dr. Elaine A. Leventhal: Assistant Professor of Medicine, H6/372 Clinical Science Center, 600 Highland Avenue, Madison, WI 53792.

© 1986 by the American Geriatrics Society

0002-8614/86/$3.50

and they will be important in developing the implications of the findings for clinical practice.

EMPIRICAL STUDIES

Study 1: Age Differences in Anticipated Reactions to Six Diseases The sample in our initial study[3] consisted of 396 adults 20 to 89 years of age, recruited at a health fair held at a large shopping center in a mid-sized Midwestern city: population 240,000. For analysis, we divided the participants into three age categories: 20 to 39 years, 40 to 59 years, and 60 to 89 years.

Questionnaires All of the respondents were asked how often they performed each of 21 health practices, eg, seeking regular medical checkups, avoiding use of salt, eating a balanced diet, getting eight hours of sleep, etc (traditionally classified as health practices), and items measuring practices to reduce emotional stress such as avoiding stressful situations, staying mentally alert and active, and looking at the positive side of things. These coping responses are the key dependent variables in this study.

Questions about representations and coping with disease focused on six different illnesses: heart attack, lung cancer, colon-rectal cancer, high blood pressure, senility, and colds. These six diseases were selected because we have found that they vary over the illness dimensions of chronicity, severity, and aging relatedness.[4] Each respondent was assigned randomly to answer questions about only one of the six diseases.

The items on the cognitive components of the representation focused on the following: 1) the respondents' beliefs about their susceptibility to the disease and their beliefs that each of 16 specific symptoms was a sign of that disease; and 2) beliefs about consequences, ie, how much the disease would affect them. Separate items asked about emotional reactions to each of the diseases.

Questions about coping covered the individual's perception of the effectiveness of each of the 21 health practices in preventing each disease. We also assessed beliefs about self-effectance in controlling or avoiding the disease, and we asked each person to judge his or her ability to monitor changes in the illness over brief (one week) and longer (five years) periods.

Hypotheses We expected to see a greater frequency of preventive health actions among older respondents, an effect reported in several studies.[5–7] Second, we anticipated that the increase in reports of preventive practices for older respondents would be related to their perceptions of greater vulnerability to the disease and judgments that if they contracted the disease it would be more severe for them.

We also expected that older respondents would report less intense emotional reactions to serious illness threats such as cancer or heart disease. Whereas older persons are more susceptible to these threats, they are an appropriate part of the older person's life pattern. Because they are expected or at least not unexpected, these diseases may provoke less intense emotional reactions[8] of anger and/or shame, although their prospects (pain, death) may be no less fright-

TABLE 1. MEANS OF REPORTED HEALTH ACTION AND COGNITIVE-AFFECTIVE BEHAVIORS BY AGE GROUP*

Behaviors	Age Group 20–39 (*N* = 173)	40–59 (*N* = 111)	60+ (*N* = 112)	*F*†
Health action				
I avoid too much physical exertion	2.0	2.4	2.6	11.4
I do regular aerobic or strenuous exercise	3.3	2.8	2.7	12.5
I have regular medical checkups	3.3	3.8	4.1	16.4
I get enough sleep	3.7	4.0	4.1	11.6
I try to breathe clean air and drink pure water	3.8	4.1	4.5	17.1
I eat a balanced diet	3.7	3.9	4.3	21.9
I avoid harmful health habits like smoking and excess drinking	3.9	4.2	4.5	9.1
I avoid salt and heavily salted foods	3.3	3.5	3.9	11.8
Cognitive-affective				
I avoid too much emotional distress	2.8	2.9	3.2	7.4
I avoid feelings like anger, anxiety, and depression	2.9	3.0	3.6	30.5
I stay mentally alert and active	4.2	4.4	4.6	13.4

Data represent response to a five-point scale ranging from never (1) to always (5).

**Selected items from Prohaska et al.*[3,10]

†*P* < .01. F *ratio for main effect of main effect of age from 3(age) × 2(sex) analyses of variance.*

ening. Our fourth hypothesis was that certain types of symptoms, especially mild chronic ones, may be perceived as sensations of normal aging and less likely to be associated with specific illnesses by older respondents.[9] Hence, we expected older persons would be less likely to say they would take medical action if they experienced such vague, ambiguous symptoms.

Results The reported frequency of the 21 health practices varied for our three age groups (Table 1): The oldest respondents reported higher frequencies of specific activities traditionally seen as health promoting, eg, regular medical checkups, avoidance of salt, and eating a balanced diet. The oldest respondents also reported higher frequencies of practices for controlling affect, such as avoiding emotional stress and staying mentally alert and active. Only one of the 21 practices, exercise, was reported at lower frequency by older respondents.

We next examined the relationships between health practices and the various attributes of the common-sense model of illness to see if they would account for reported differences in health practices between age groups. Our hypotheses suggest that differences in reported health practices for the three age groups may reflect differences in one or more of the following three areas: 1) the cognitive representation of diseases (vulnerability, severity, symptoms, etc); 2) emotional reactions to diseases; or 3) differences in various aspects of coping, eg, perceived effectiveness of the health practices in preventing illness or beliefs in the ability to perform these actions.

Although we found differences between the three age groups in their representations of the diseases, the differences are neither large nor consistent. Thus, in this sample of well persons, the older subjects did not see themselves as more vulnerable to the two cancers or to colds, but did see themselves at greater risk for high blood pressure, heart attack, and senility. The elderly also perceived colds to be more serious for themselves. There were no age differences for the perception of the time it takes for these diseases to develop. Respondents' beliefs as to how they would react emotionally if they developed these diseases replicated prior findings[1] for two of three items: The oldest respondents reported feeling less anger and fear, but they did not report less shame (Table 2).

TABLE 2. AGE GROUPS DIFFERENCES IN EMOTION REACTIONS TO ILLNESSES

	Mean		
Emotion	Young	Middle Age	Old
Anger*	2.9	3.1	2.6
Shame	1.8	1.6	1.7
Fear*	3.2	3.3	2.9

Data represent response to a five-point scale from not at all (1) to extremely (5).

*P < .05. *F ratio for main effect of age from 3(age) × 6(illness) analyses of variance.*

TABLE 3. PERCENTAGE OF RESPONDENTS CHECKING SYMPTOMS AS WARNING SIGNS OF SPECIFIC ILLNESSES

	Age Category (yr)		
Symptom	20–39 ($N = 173$)	40–59 ($N = 111$)	60+ ($N = 112$)
Weakness	43	31	29
Aches	36	24	21

$\chi(2) = 7.6$ *weakness*, 6.4 *aches*, P < .05.

We then looked at symptom processing, ie, the interpretation of the concrete warnings of disease, to see if it differed by age group. If the elderly ignore mild symptoms because they attribute them to aging, older persons might believe they are well even when they have the same symptoms as younger persons and engage in different health and illness behaviors.

The respondents were asked to indicate whether each of 16 symptoms would be considered a warning of a given illness (cold, hypertension, colon-rectal cancer, lung cancer, senility, or heart attack). The three age groups associated the same specific symptoms with specific illnesses, with two exceptions: Older respondents were less likely to use weakness and aching as signs of illness (Table 3). It may be that both of these symptoms are less frequently used by older respondents because they are more common at an advanced age. This hypothesis is consistent with the finding that older respondents are no different than younger respondents in the frequency in which they use the remaining symptoms.

Finally, we examined reports of coping reactions beginning with the perceived effectiveness of the 21 health practices in preventing specific illnesses (Table 4). First, we found that people believed different behaviors effective for different diseases. For example, the avoidance of salt was believed to prevent high blood pressure, but judged ineffective against colds. Table 4 provides the means for the coping responses.

Given that older people are more likely to report using these practices, we wondered whether or not they perceived them to be more effective in preventing the six specific diseases: They do not. Thus, older persons make greater use of these health promoting actions even though they do not have stronger beliefs in their efficacy in preventing the six diseases. Only one preventive practice was perceived differently by the three age groups: Younger respondents viewed regular exercise as a disease preventive, whereas older respondents saw avoiding physical exertion as more effective for preventing heart attack and lung cancer.

TABLE 4. MEANS FOR PERCEIVED EFFICACY OF HEALTH ACTIONS AND COGNITIVE-AFFECTIVE BELIEFS BY ILLNESS TYPE*

	Illness Type						
Behavior	**Heart Attack**	**High Blood Pressure**	**Lung Cancer**	**Colon-Rectal Cancer**	**Senility**	**Cold**	**F†**
Health action							
I can help prevent ____by:							
Avoiding harmful health habits like smoking and excess drinking	4.4	4.4	4.4	3.5	3.6	3.8	11.6
Getting enough sleep	3.5	3.5	3.0	2.8	3.2	3.8	12.2
Avoiding salt and heavily salted foods	4.0	4.3	2.8	3.0	3.3	2.7	45.4
Having regular medical check-ups	3.8	3.7	3.6	3.7	3.2	2.3	18.8
Doing regular aerobic or strenuous exercise	3.8	3.9	2.9	2.9	3.2	[illegible]	15.2
Avoiding too much physical exertion	2.5	2.0	1.8	2.1	2.0	2.1	4.1
Trying to breathe clean air and drink pure water	3.4	3.0	3.8	2.9	3.2	3.2	6.2
Cognitive-affective							
Avoiding too much emotional distress	3.9	4.0	2.7	3.0	3.1	3.0	21.2
Avoiding feelings like anger, anxiety, and depression	3.7	4.0	2.8	3.0	3.3	3.0	14.7
Staying mentally alert and active	3.9	3.7	2.9	2.9	4.0	3.2	17.6

Data represent responses to a five-point scale ranging from strongly agree (1) to strongly disagree (5).

**Selected from Prohaska et al.*[3]

†P < .01. F ratio for main effect of illness from 3(age) × 6(illness type) analyses of variance.

In summary, the findings suggest many common factors in the representation of these six diseases across the life span, the exceptions being an increased sense of vulnerability to three of the diseases (senility, high blood pressure, and heart attack) by the elderly. Consistent with their reports of vulnerability, older respondents also report a greater range of health actions. Somewhat paradoxically, the oldest respondents also appear less responsive to symptoms that might indicate serious systemic disease and they are no more convinced of the effectiveness of their health actions than are younger respondents.

The contrast between elderly patients' reports of vulnerability and their nonresponsiveness to symptoms suggested the need for a more detailed study of age differences in the interpretation of symptoms. Two possibilities exist: The elderly may be less responsive to symptoms in general, or they may interpret some symptoms of illness as symptoms of aging. For example, elderly may interpret many stable, daily symptoms as due to age rather than illness. These attributions may influence subsequent health and illness behavior, with elderly persons differing from younger persons in the way they cope with mild chronic illness yet similar to younger persons in the way they cope with severe and/or short-term illness. We would also expect that age differences in coping with mild, stable symptoms would disappear if an illness label is attached to these symptoms so they can no longer be attributed to age.

Study 2: Response to Illness Scenarios We decided to test the above assumptions in a sample of healthy adult respondents.[10] Our first hypothesis was that attribution of symptoms to aging would reduce an individual's tendency to generate health and illness behaviors. Our second and third hypotheses were that an aging attribution would be more frequent for mild, long lasting symptoms, which would be ambiguous as signs of illness, and that this attribution would be more frequent in older respondents.

We wrote four illness scenarios in which the severity, duration, and the presence of an illness label were varied. Our measures included the attribution of the symptoms to aging and choice of health behaviors to cope with the scenario.

TABLE 5. PERCENTAGE OF RESPONDENTS INTERPRETING SYMPTOM DESCRIPTIONS AS DUE TO AGING

	Age Category			
Illness Script	20–39 yr (*N* = 120)	40–59 yr (*N* = 118)	60+ yr (*N* = 81)	Total
Short severe	3	10	20	10
Short mild	20	39	60	37
Long mild	15	36	55	32
Long mild labeled	25	55	52	44
Total	16	35	47	

Only half of the total sample (N = 614) was provided the aging attribution question.

Six hundred fourteen respondents were recruited from the community: 253 aged 20 to 39, 219 aged 40 to 59, and 142 between the ages of 60 to 83 years. Each respondent read one of the four illness scenarios. The scenarios described: 1) a short (three-day) severe symptom episode; 2) a short-mild symptom episode; 3) a long (few weeks) mild symptom episode; and 4) a long-mild symptom episode that was given a specific label, ie, "walking pneumonia." Respondents were asked to imagine that the scenario described their current health status and how likely they would be to take each of 26 different actions for coping with the episode. These were combined into ten dependent measures (seven scales and three medical care items), presented in Table 6. They also indicated whether the illness scenario could reflect their own aging.

Our first analysis showed that brief, severe symptoms were less likely to be attributed to age and that older respondents were more likely to attribute symptoms to aging, even for the brief, severe symptoms (Table 5).

These findings confirm the hypotheses that mild symptoms are more likely attributed to aging and that older respondents are more likely to make an aging attribution. Contrary to our expectations, neither the duration of the symptoms nor the presence of an illness label (walking pneumonia) affected attribution of the symptoms to aging: The long duration, mild, labeled symptoms were attributed to aging by 44% of the respondents; the long, mild, unlabeled by 32%; the short, mild, unlabeled by 37%; and the short, severe, unlabeled by 10%. The findings are also contrary to the hypothesized interactions that older persons would more likely make aging attributions only for mild, long lasting and not for severe symptoms, and that an illness label would eliminate aging attributions.

Our second set of analyses examined whether people who attributed symptoms to aging would be less likely to take active steps to evaluate and cope with the described symptoms and be more likely to report passive acceptance of them. As seen in Table 6, the data confirmed our expectations: Respondents who attributed symptoms to aging were more likely to say they would cope by: 1) waiting and watching; 2) accepting the symptoms; 3) denying or minimizing the threat; or 4) postponing or avoiding medical attention (eg, waiting to bring up the symptoms during their next scheduled medical appointment and not calling a doctor for an appointment). Attribution of symptoms to aging also was associated with reports of weaker emotional reactions.

These findings suggest that as individuals age they are more likely to assume that symptoms, especially mild chronic ones, are due to aging, thus influencing the strategies they adopt to cope with these symptoms. Although the data supporting this conclusion are consistent with our hypotheses, it is important to recognize that the effects are not large. The data also suggest, at least for the current set of symptoms, that

TABLE 6. CORRELATIONS BETWEEN COPING STRATEGIES, CHRONOLOGIC AGE, AND PERCEPTION OF SYMPTOMS TO AGING

Coping Scales	Chronologic Age	Aging Attribution
Affective response	−.01	−.13*
Self-help	.22*	−.10
Acceptance	.01	.32*
Help/comfort from others	−.04	−.11
Monitor/delay	−.06	.24*
Deny/minimize	−.01	.26*
Gather information	−.15*	.01
Medical care items		
Call a doctor	.08	−.23*
Wait to bring up symptom during next visit	.16*	.34*
Use emergency room	.11	−.09

Only half the total sample (N = 614) was provided the aging attribution question.

*P < .01; N = 334.

symptom severity has a stronger impact on coping reactions than either duration or labeling of the symptom, and it strongly influences attribution to aging. Because mild vague symptoms such as fatigue increase with age, and because older respondents are more likely to attribute such symptoms to age, aging attributions can be presumed to have increasing impact on older persons' decisions to take health actions and to seek or neglect to seek medical care.

IMPLICATION FOR PRACTICE AND POLICY

These findings, plus those from our ongoing research into symptom perception, can serve to improve the health care professional's understanding of the complexities that guide individual health behaviors for care seeking as well as responses to therapeutic interventions. We are collecting additional data on several patient populations to confirm the above findings and to test other hypotheses about the determinants of adopting various self-selected health actions including seeking medical care. We hope to understand why older persons report an increasingly large number of health practices, consistent with their views that they are susceptible to chronic illness and more reversible acute illness, yet seem more accepting of and less likely to seek medical care for symptoms such as tiredness and weakness.

The seeming paradox, ie, taking many health promotive actions while accepting, ie, not responding to, illness symptoms, is partially resolved by the tendency for older persons to assume these symptoms are signs of age rather than signs of illness. If attributing symptoms to aging means the symptoms are benign, it makes sense either to ignore them or attend to them only to increase comfort. There is a second possible meaning, however, of attributions to aging: that *all* symptoms, benign or malignant, are more common with age. This latter meaning is congruent with all aspects of our data. Thus, there are the mild aches and pains of aging, benign events due to bodily changes, and there are the symptoms of serious, chronic disease, to which the elderly consider themselves increasingly vulnerable. It is this latter meaning of aging attribution, ie, increased susceptibility to serious illness, that allows older persons to attribute symptoms to aging even when they are severe or when they are given an illness label. The two meanings fit the two often noted and contrasting patterns of health behavior in the elderly: 1) ignoring symptoms that need treatment, and 2) hypervigilance to symptoms that may be benign. They also make sense of the seemingly contradictory finding of overuse of medical care by the elderly in response to symptoms that are physically mild and not serious but perceived as serious and potentially life threatening.[11]

What questions do these findings raise for practice? How should the practitioner react to the older patient's apparent eagerness to adopt a wide range of culturally accepted actions for disease prevention given the meager empirical data to support their usefulness? Given their growing sense of vulnerability, we can anticipate that older people will be especially susceptible to myths and fads and may adopt practices that are of little benefit. Should the practitioner discourage the performance of these actions? Should he or she at the very least find out what the elderly person is doing to see if any of these practices are hazardous or substituted for more successful forms of preventive behaviors?

Second, how should the practitioner deal with the tendency to ignore symptoms because they are seen as benign signs of aging rather than signs of illness? Do the elderly delay seeking health care because they have difficulty detecting symptoms against the background noise of an increasing load of chronic illness? Or do the elderly notice but confuse symptoms of illness with signs of aging? Or does the threat of chronic illness, and the belief that chronic conditions are uncontrollable and fatal, induce a fatalistic outlook that encourages older people to deny the premonitory signals of chronic diseases? Finally, do their many self-selected preventive health practices generate a false sense of security that makes them slow to recognize illness signals, putting them at greater risk because of delay in diagnosis and treatment of controllable, chronic illness?

How the practitioner reacts to the older person's willingness to live with symptoms depends in part on answers to the above questions. If the doctor ignores the tendency to view symptoms as benign signs of aging, he or she may encourage delay in use of care that allows treatable and controllable illness to become virulent and uncontrollable. For example, Funch (personal communication, June 14, 1985) has found that attribution of symptoms to aging led to delay in seeking care by elderly patients diagnosed with colon-rectal cancer. On the other hand, encouraging attention to minor symptoms may excite hypervigilance to the broad range of vulnerabilities believed to be associated with aging, and snare a generation of elderly in the trap of hypochondriacal illness behavior. At the present, it seems reasonable to recommend that practitioners carefully explore the meaning attached to symptoms such as weakness and aching. This would, at the minimum, permit discussion and the possibility of setting realistic criteria for evaluating changes in symptomatology so that the elderly person can avoid excessive delay in seeking medical care, as well as avoiding hypervigilance and overuse of the care system. This simple recommendation makes sense in light of data showing that elderly respondents sometimes prefer to leave the interpretation of symptoms to their physician.

We should point out that it may not be easy to change many of the age-related biases in illness and symptoms perception and the use of inappropriate, self-selected health practices. The older person may have a lengthy personal history and substantial social support for various beliefs and practices, no matter how incorrect they may be. Moreover, many of these beliefs and practices may be self-reinforcing. Garlic and 1000 mg of vitamin C may have a direct effect on the individual's sense of self-control, reduce feelings of uncertainty, and increase positive moods, no matter how useless they are for combatting colds, cardiovascular disease, and cancer. Indeed, they may be among the few techniques for enhancing mood for many elderly persons. With respect to symptoms, the world of the elderly is increasingly ambiguous: As one ages, it is increasingly likely that one will experience body sensations that are meaningless or all too meaningful. Ambiguity of this magnitude can lead to abrupt shifts from hypervigilant overconcern to ignoring by "normalization."[12]

To substitute more rational therapies for the elderly's elaborate, sometimes ill chosen network of measures for health disease prevention and health promotion, it will be essential that the replacement measure be seen as acceptable before the ineffective techniques can be or will be removed. It also will be necessary to penetrate to the core of the patient's interpretive system that represents symptoms as threatening or benign. It is likely to be very difficult to alter the hypervigilance reaction. It may seem that no amount of reassurance is adequate to convince the elderly patient that he is well if he believes he is suffering from undetected cancer and being ignored and/or misled by a physician who is uncaring or falsely reassuring in order to avoid a threatening topic. Direct exploration of fears and identifying, discussing, and correcting the patient's misinterpretation of specific symptoms may be essential for building confidence and removing hypervigilance. Recent studies of highly elaborate methods for reducing arousal support the importance of an active yet supportive interpersonal relationship as a key to the amelioration of arousal.[13] These and other factors supporting protective health behaviors will be explored in greater detail in subsequent investigations.

This research shows us that not only does the body physically change with age, but behaviors, especially health behaviors, also change with age. The nature of changing health behaviors reflects the individual's unique psychosocial and medical history.

Therefore, it is clear that medical education must include information on normal aging and the pathophysiology of the chronic diseases and presentations of acute illness in the old. It is also critical that medical practitioners understand that the clinical skills necessary for assessment must be adaptable to illness behaviors of their older patients.

REFERENCES

1. Leventhal E: Aging and the perception of illness. Res Aging 6:119, 1983
2. Leventhal H, Nerenz D: A model for stress research with some implications for the control of stress disorders, *in* Meichenbaum D, Jaremko M (eds). Stress Reduction and Prevention. New York, Plenum Press, 1983, p 5
3. Prohaska T, Leventhal E, Leventhal H, et al: Health practices and illness cognition in young, middle aged, and elderly adults. J Gerontol 40:569, 1985
4. Keller M, Prohaska T: Age influences in illness perception. Paper presented at the annual meeting of the Gerontological Society of America, San Francisco, November 1983
5. Belloc NB, Breslow L: Relationship of physical health status and health practices. Prev Med 1:409, 1972
6. Coburn D, Pope C: Socioeconomic status and preventive health behavior. J Health Soc Behav 15:67, 1976
7. Harris D, Guten S: Health-protective behavior: An exploratory study. J Health Soc Behav 20:17, 1979
8. Neugarten B, Datan N: Sociological perspectives on the life cycle, *in* Baltes PB, Schaie KW (eds): Life-Span Developmental Psychology: Personality and Socialization. New York, Academic Press, 1974
9. Kart C: Experiencing symptoms: Attributions and misattributions of illness among the aged, *in* Haug M (ed): Elderly Patients and Their Doctors. New York, Springer, 1981
10. Prohaska T, Leventhal E, Leventhal H: Age patterns in illness perception and symptom utilization. Paper presented at the 37th annual meeting of the Gerontological Society of America, San Antonio, November 1984
11. Haug M: Age and medical care utilization patterns. J Gerontol 36:103, 1981
12. Mechanic D: Social psychologic factors affecting the presentation of bodily complaints. N Engl J Med 286:1132, 1972
13. Cuthbert B, Kristeller J, Simons R, et al: Strategies of arousal control: Biofeedback, mediation and motivation. J Exper Psychol [Gen] 110:518, 1981

BLANK PAGE

Copyright 1985 by
The Gerontological Society of America

This paper studies the feasibility of making multidimensional functional assessments by asking older persons to respond directly to a questionnaire, thus obviating the need for personal interviews. Data were gathered by performing both types of assessment with a sample of 22 elderly persons residing in a housing project for low-income persons. Analysis of ratings and objective scores suggests that among relatively independent, well elderly individuals, self-administered assessment should be the mode of choice. Clinical and survey research applications are discussed.

Key Words: Multidimensional functional assessment, Interrater reliability, Self-administration, Objective scoring, Well elderly.

Multidimensional Functional Assessment in Two Modes[1]

Woodrow W. Morris, PhD[2] and Sandra Boutelle, BA[3]

Multidimensional functional assessment of older persons is gradually becoming a regular part of the overall planning for the provision of services to those who come to the attention of providers. The best-known methodology for such assessment is the so-called OARS Methodology developed at Duke University at the Center for the Study of Aging and Human Development (1978). A second method, using many of the items employed in the OARS methodology and based on a conceptual scheme of human development, is the Multilevel Assessment Instrument (MAI) developed by Lawton and his colleagues (1982) at the Philadelphia Geriatric Center.

One major obstacle to the universal assessment of relatively independent, well elderly adults using either of these instruments is that the interview which is required may take from 45 minutes to more than 1 hour to complete. Thus, if it were desired to assess 100 persons, at least 100 hours of interview time alone would be necessary. This would take a single interviewer 25 days at the rate of four participants per day; five interviewers seeing four persons each day would complete the job in 5 days.

Slavonic (1983) studied self-administered assessment by obtaining responses from about 30 male geriatric veterans to the OARS questionnaire which had been mailed to them and returned by mail to the author. Responses were scored by means of a computer-based scoring program developed by George et al. (1982). Using interview-based protocols as criterion, Slavonic correlated self-administered (mail) scores and found highly significant moderate-sized correlations between the five health dimension scores and the same five health dimension scores in the interview. She concluded that the mail-out approach is a highly promising method for conducting health status surveys of the elderly.

If consideration is limited to independent, well elderly, it would seem appropriate to assume that they themselves should be capable of providing the essential information for assessment, using a self-administered format of the assessment instrument. Such an approach would require only a carefully worded set of instructions, the self-administered form and, at most, a brief (e.g., 5 to 10 minutes) visit with each participant to clarify any unclear responses and/or to obtain replies to unanswered items.

This study, therefore, examined four research questions about this kind of assessment:

1. With what reliability will four judges be able to rate assessment protocols from a sample of relatively independent, well elderly persons?
2. To what degree will the ratings of the judges based on interview protocols agree with those based on self-administered protocols?
3. Will the sequence with which the two modes are administered be reflected in any systematic differences in ratings?
4. Can a system of objective scores be devised that will agree with the ratings of the judges?

Participants

A sample of 24 residents of a housing project for low-income elderly and handicapped persons was invited and agreed to participate in the study designed to seek answers to the research questions. Halfway through data collection, two males withdrew, leaving a sample of 12 female and 10 male participants. As shown in Table 1, the ages of the participants ranged from 63 to 89 years. Of those who had some post-high school education, three had

---

[1] The authors are grateful to Hermine McLeran, Coordinator of the Aging Studies Program; Janis Eldredge, Teaching Assistant, Preventive and Community Dentistry, College of Dentistry, both of The University of Iowa; and Phyllis Ferrel, Administrator, Ellen Nielsen, and residents of Ecumenical Towers, Iowa City, IA, for their assistance as raters and participants in this study.

[2] Associate Dean and Professor, College of Medicine, The University of Iowa, Iowa City, IA 52242.

[3] Graduate of the Aging Studies Program, The University of Iowa, Iowa City, IA.

Table 1. Demographic Characteristics of the Respondents

Characteristic	Males *n*	Males %	Females *n*	Females %	Totals *n*	Totals %
Age						
60-69	3	30	4	33	7	32
70-79	4	40	2	17	6	27
80-89	3	30	6	50	9	41
Marital Status						
Single	2	20	2	17	4	18
Married	6	60	1	8	7	32
Widowed	2	20	8	67	10	45
Divorced	0	0	1	8	1	5
Education						
5-8 years	3	30	1	8	4	18
Some high school	5	50	3	25	8	36
High school graduate	1	10	3	25	4	18
Post-high school	0	0	2	17	2	9
Some college	0	0	1	8	1	5
Some graduate school	1	10	2	17	3	14
Annual income						
$ 3,000–$ 4,999	1	10	1	8	2	9
$ 5,000–$ 7,000	4	40	5	42	9	41
$ 7,000–$ 9,999	4	40	6	50	10	45
$10,000–$15,000	1	10	0	0	1	5

completed collegiate graduate or professional school programs. All were low-income persons with annual incomes ranging from $3,700 to $15,000, equally divided above and below $7,000.

Design of the Study

Two forms of the Duke University *Multidimensional Functional Assessment Methodology* were used. In addition to the questionnaire described in the manual (Duke, 1978), which we shall refer to as the *interview mode*, a *self-administered mode* was developed by converting the wording of the original items used in the interview to direct questions addressed to the respondent followed by multiple-choice answers. Although care was taken to maintain wording and response choices similar to those in the original instrument, some changes were made.

In the *Social Resources* section, additional questions were added to seek information regarding the number of clubs and fraternal and social organizations to which the respondents belonged and their degree of participation in them; whether respondents belonged to churches or synagogues and the extent of their attendance; and respondents' ratings of their social resources at the present time (excellent, good, fair, or poor), and their social resources now compared to those of 5 years ago.

In the *Mental Health Status* section, selected items from the *Social Readjustment Scale* (Holmes & Rahe, 1967) were added, and respondents were asked to rate their mental and emotional health at the present time and to compare it to their health 5 years ago. The mental status examination used in the opening portion of the Duke methodology was deleted.

In the *Physical Health Status* section, respondents were asked to rate their present physical health status and to compare it to their status 5 years ago.

In the *Activities of Daily Living* (ADL) section, all of the activities were listed and respondents were asked to rate the degree to which they were able to perform each on a scale of "Without help," "With some help," and "Completely unable." Respondents were also asked to rate their present ability to carry on the activities of daily living and to compare their current functioning now with that of 5 years ago.

In order to make the self-administered format as easy to read as possible, a larger, 10-pitch type style was used, double-spacing between items and using one and one-half spaces between lines within items. This resulted in a 15-page booklet using only one side of each page.

Procedures

The respondents were divided into two groups, each with 11 participants (5 men and 6 women). One group was first assessed by interview over a span of 3 days by a single interviewer. Two weeks later, the self-administered form was distributed to the same persons, and at that time it was also distributed to the members of the second group. Two weeks later, the members of the second group were assessed by interview by the same interviewer.

Four judges assigned ratings based on both interview and self-administered protocols using written sets of rating criteria based on those used at Duke. Two of the judges were university staff members who had completed training in the assessment methodology; the authors were the other two judges.

All of the protocols were coded and no names or other identifying information was made available to the judges, although it should be noted that all knew that the participants were low-income persons qualifying as residents of the HUD project in which they were living.

Rating criteria and other instructions were provided to the judges. The rating criteria deviated somewhat from that used in the OARS methodology since we have always believed that rating scheme to be biased toward impairment (setting aside four of the six rating categories to suggest impairment and two for excellent or good functioning). In this study, the rating of "3," which was defined as "Mildly impaired" in the original instrument, was changed to "Moderate," and "4" became "Mildly impaired;" "5" was used to indicate "Moderately impaired," and "6" signified "Severe impairment." Thus, ratings of 1-3 were used to signify positive status and ratings of 4-6 were used to reflect negative status.

The meaning of the ratings may be made more specific by describing the significance of high (i.e., 1 and 2) ratings. In the case of social resources, such ratings suggest an individual who has numerous and consistent contacts with other persons both as individuals and in group settings. More often than not, they have family members who are accessible and with whom they have frequent and satisfying contacts. People high in social resources tend to belong to and participate in social groups as well as religious groups. Finally, such persons report that their social resources are as plentiful now as in the past and that they are both satisfying and supportive.

Persons high in economic resources have income and assets which they regard as sufficient to meet their current daily needs as well as future emergency situations. Income and assets place them clearly above poverty levels and they report no difficulties in paying their monthly bills without receiving supplemental financial assistance of any kind. These individuals have both Parts A and B of Medicare as well as supplemental health insurance. In general, such persons believe that they are doing better financially than others their age and that their financial resources are the same or better than they were 5 years previously. Finally, these people indicate that they can afford "small luxuries," have enough money to take care of future needs and, therefore, express no fears for their financial futures.

Those who rate high in mental health report that they seldom worry about things, find life more or less exciting, and are satisfied with life in general. Signs and symptoms of anxieties, depression or other emotional problems are absent. Overall, they describe their mental health as good to excellent, and they believe that this aspect of their lives is about the same or better than it was 5 years earlier.

Older persons rating high in physical health report seeing a physician or other health care professional less frequently than average; they have not been a patient in any health care institution recently, and they believe that they have no need for health care or treatment beyond what they may be receiving currently. As might be expected, such individuals report having no need for supportive devices such as canes, crutches, walkers, or wheelchairs since they have no outstanding disabilities. Their eyesight and hearing are good to excellent, although many wear glasses or contact lenses. They report a very low number of major illnesses and consume a minimum of prescription or over-the-counter medications. Finally, these are people who believe that their health is good to excellent and that it is about the same or better than it was five years previously.

Persons rated high in their ability to carry on the activities of daily living are those who report being able to perform self-maintenance and instrumental functions without help from others. They also believe that their abilities in this sphere are good to excellent and they they are about the same now as they were 5 years ago.

The more the ratings of individuals deviate from this high profile, the more their resources, statuses, and abilities are considered less than ideal.

With these factors in mind, the judges made their ratings privately and independently with no other information than what was contained in the protocols (with exception of the interviewer, who had personal contacts with the participants). The judges made their ratings on each group of protocols in the order in which they had been administered.

Finally, in order to study the feasibility of objectifying the assessment process, a scoring system was devised separately for the interview and self-administered modes. Each item was scored by assigning numerical weightings to the various responses in keeping with the rating criteria; i.e., positive, healthy, favorable responses were scored "1," with higher numbers assigned to responses which indicated deviations toward impairment.

Data Analysis

Analyses of variance and kappa statistics of the ratings among the four judges were calculated for ratings based on both interview and self-administered protocols, taking into account the sequence with which the protocols were obtained. Finally, objective scores were derived as described earlier and were correlated with the ratings of the judges separately for the two data sources.

Reliability of Ratings

The data in Table 2 were obtained by calculating the kappa statistics to measure the extent of agreement among the four judges. The statistical analysis followed the procedures outlined by Fliess (1971) and Light (1971). In addition, analysis of variance of the ratings was calculated, from which intraclass correlation coefficients were obtained.

The correlation coefficients among the several pairs of judges were high, and no significant differences were found among the several pairs of judges on any of the five variables (Table 2). The agreement among the four judges, as estimated by kappa, shows that, in all instances, agreement among them was greater than that which would have been expected by chance. The intraclass correlation coefficients, all statistically significant at an alpha level of .01, were as follows for the interview-based ratings: social resources, .92; economic resources, .90; mental health, .90; physical health, .95; and activities of daily living, .93. Analogous results for the self-administered ratings were social resources, .86; economic resources, .94; mental health, .84; physical health, .82; and activities of daily living, .95. It is clear from both the kappa analysis and the intraclass correlations that there was significant agreement among the four judges.

Agreement Among Judges and the Sequence of Administration

The ratings of the judges were submitted to analysis of variance and, since no significant variances were revealed, the ratings were averaged. The average ratings based on interview protocols were compared with the average ratings based on self-administered protocols with findings that suggest no significant differences between these two modes of data collection. Analysis of the sequence in which the protocols were administered (i.e., interview first or self-administered first) indicates that sequence

Table 2. Overall Reliability of Ratings

	Interview Mode			Self-Administered Mode		
Variables	Kappa	Standard Error	Z	Kappa	Standard Error	Z
Social resources	.5410	.0435	12.44*	.5958	.0439	13.57*
Economic resources	.3219	.0338	9.52*	.3020	.0390	7.75*
Mental health status	.3436	.0354	9.70*	.2654	.0361	7.35*
Physical health status	.4259	.0453	9.40*	.2120	.0524	4.05*
Activities of daily living	.3352	.0400	8.38*	.5905	.0410	14.42*

Note. Agreement among four judges on ratings based on interview and self-administered protocols; $n = 22$.
*$p < .001$

Table 3. Combined Ratings by Sequence

	Interview First		Self-administered Second			Self-administered First		Interview Second		
Variable	*M*	*SD*	*M*	*SD*	F^a	*M*	*SD*	*M*	*SD*	F^a
Social resources	1.68	0.88	1.93	1.02	1.51	2.23	1.20	1.86	0.88	2.64
Economic resources	2.18	0.79	2.41	0.84	1.71	2.39	0.97	2.48	1.11	0.17
Mental health status	2.16	1.12	2.11	1.13	0.04	2.20	0.93	2.11	0.95	0.21
Physical health status	3.20	0.98	3.16	1.03	0.04	3.11	1.38	3.30	0.98	0.51
Activities of daily living	2.16	1.22	1.59	1.30	0.26	2.11	1.15	2.05	0.96	0.09

Note: The effective range of ratings in all cases was from 1 to 4; less than 3% of the 880 ratings were "5," most of which were in the physical health area.

[a] Number of degrees of freedom in each comparison was 86 and 1; F value required at the .01 level = 7.20.

Table 4. Product Moment Correlations Between Objective Scores and Ratings Based on Interview and Self-Administered Protocols

Variable	Interview Protocol *r*	Self-Administered Protocol *r*
Social resources	0.69*	0.83*
Economic resources	0.84*	0.71*
Mental health status	0.85*	0.80*
Physical health status	0.86*	0.84*
Activities of daily living	0.83*	0.95*

*$p < .01$.

did not result in any meaningful differences at better than the .01 level, as shown in Table 3.

Objective Scores

Objective scores derived from interview protocols were correlated with the ratings of the judges for each of the five areas with results as shown in Table 4. All of the correlations were significant at the .01 level of probability. Table 5 presents the alpha coefficients of reliability based on objective scores derived from both interview and self-report protocols.

Comparison of Findings with Duke University Experience

Fundamentally, responses obtained either from interviews or self-administered assessment are sought in order to secure accurate information regarding the functional status of respondents in terms of the five dimensions comprising the methodology. Fillenbaum and Smyer (1981) reported on an assessment of the interrater reliability of the OARS methodology. They utilized a sample of 11 users of the methodology, each of whom rated the protocols of 30 participants in a validity study. Each rater assigned ratings on each of the five dimensions for all 30 participants.

Interrater reliability was assessed using the intraclass correlation coefficient derived from an analysis of variance performed on each of the five scales. The obtained results, all significant at an alpha level of .001, were as follows: social, .823; economic, .783; mental health, .803; physical health, .662; and self-care capacity, .865. The authors concluded that it was evident that substantial rating agreement existed among the group of raters. Our experience presented here found equally high intraclass correlations among the judges for both the interview-based and the self-administered ratings.

Fillenbaum and Smyer (1981) noted that the raters in their study were in complete agreement on 74% of the ratings. In the present study, identical ratings among the four judges occurred over half of the time; agreement within a 1-point spread in the interview mode occurred as follows: social, 95%; economic, 86%; mental health, 77%; physical health, 77%; and activities of daily living, 86%. For the self-administered protocols, agreements within a one-point spread were social, 82%; economic, 91%;

Table 5. Alpha Coefficients of Reliability of Objective Scores Derived from Interview and Self-Administered Protocols

Variable	Interview (*n* = 22) *M*	Interview (*n* = 22) *SD*	Self-Administered (*n* = 22) *M*	Self-Administered (*n* = 22) *SD*	t^a	Alphas *I*	Alphas *SR*
Social resources	9.91	2.01	10.23	2.65	0.44	0.49	0.69
Economic resources	15.10	2.87	15.05	2.83	0.06	0.79	0.82
Mental health status	25.32	4.89	25.59	4.91	0.18	0.86	0.85
Physical health status	79.87	8.66	80.96	7.86	0.43	0.78	0.73
Activities of daily living	17.05	2.74	17.23	2.90	0.21	0.81	0.77

[a]With $df = 42$, $t = 2.704$ is required at the .01 level of probability.

mental health, 68%; physical health, 73%; and activities of daily living, 85%. Overall disagreement on placement in an impaired or unimpaired rating category (in this study ratings of 1-3 compared to ratings of 4-6) occurred only about 9% of the time. These findings support the reliability with which ratings based on both interviews and self-administered approaches may be made by trained raters.

Although these results are encouraging in that they demonstrate that skilled judges agree on their ratings, whether based on interview or self-administered protocols, it appears that it would be feasible to dispense with the use of judges altogether by devising and refining objective sources that might be used in lieu of ratings. Table 4 shows that correlations between objective scores and ratings are high enough to suggest confidence in such scores.

Practical Applications

There are many situations in which assessment of the functioning of older persons would have been of value had costs, time factors, and person-power been available for the implementation of assessment procedures. Now, with the demonstration of the feasibility of self-administered assessment at least among well, relatively independent elderly persons, it should be possible for agencies concerned with needs assessment, case management, evaluation of functioning over time, and admission to various living arrangements for the elderly to consider making functional assessments. Self-administered assessment also should be practicable as a tool in large-scale community surveys in which information is sought concerning the service needs of older citizens for planning service programs or new housing units or simply to better understand the demographics of the elderly segment of the population.

Clinical Applications

Multidimensional functional assessment is essential to good case management. It can be a valuable tool for making wise, informed decisions regarding individuals who apply for admission to a variety of special living arrangements for older adults, including retirement homes, housing for low-income elderly and handicapped persons, congregate living arrangements for "frail" elderly, residential care, and, possibly, intermediate care facilities.

Long-term care providers need systematic information about the functional levels of their residents as they relate to the services that the facilities are prepared to supply. They need to know that important behaviors can be measured and how such functions change over time. Thus, the functional assessment of applicants and residents can provide important information regarding the extent to which the individual's functioning fits the pattern of services offered. If assessment is conducted over time — say once a year — changes in any of the five areas assessed may be monitored, behavioral modification efforts instituted, and their effects measured. Multidimensional functional assessment could also be a useful addition to the usual intake procedures in a wide variety of health care settings, including medical and dental outpatient clinics, hospitals, adult day health care programs, and community and home health care service agencies.

The geriatric patient needs to be seen and treated as a "whole" person rather than simply on the basis of presenting symptoms. Such a person will surely benefit if his or her conditions are seen against the background of an assessment of the five broad areas of functioning. Physicians, dentists, nurses, pharmacists, and other professional health care personnel need to be cognizant of, for example, the implications to an individual's physical health or his or her social and economic resources, mental health status, and ability to carry on the activities of daily living. Furthermore, these same factors are of value in considering alternative sources of health care such as whether care can be provided at home, elsewhere in the community, or in a long-term care facility.

Community Surveys

Studies conducted by the Comptroller General o the United States (Laurie, 1977; U.S. General Accounting Office, 1980) are models of investigations that yield valuable data using multidimensional functional assessment methods. These studies sampled 1,609 older persons in Cleveland, Ohio, who were interviewed over a span of 6 months and re-interviewed a year later. Already available data based o interviews of 868 persons in Oregon and 128 persons in northeastern Kentucky were also analyzed. The reports do not specify the number of interviewers who were employed to conduct these studies, bu they must have entailed great costs in time, money and energy. The studies were valuable because they shed light on differences between rural and urban elderly, differences by regions of the country and relative conditions with respect to health, security, loneliness, outlook on life, extent of impairment, need for services, unmet needs, and the predominant sources of help for older persons. Such large-scale surveys form the basis for helping to develop a national policy to better provide for the elderly.

From our findings regarding self-administered assessment, future large-scale surveys might be carried out at a fraction of the cost of studies using interviewers. This should encourage those who are concerned with policy studies or community-wide assessment for particular purposes, but who might otherwise be unable to do so because of cost and personal needs, to proceed to enter the fray with a small budget and only clerical staff.

An example of the latter may be seen in an Iowa City, Iowa study (Munson, 1983) designed to estimate the interest of the elderly population of Johnson County in congregate living facilities. A random sample of 600 persons 55 years of age and older was drawn from available population lists. A response rate just under 50% was obtained, and the 284 (95%) usable responses formed the basis of the study. In addition to specific items relating to available services and attitudes toward congregate housing, the bulk of the self-administered questionnaire comprised items taken from the OARS methodology. No followup was required since a comparison of the sample obtained with the population sought showed an adequate "fit."

The original intent of the Iowa City study was to measure the demand or need for congregate housing in Johnson County. Upon the completion and analysis of the survey, it was clear that the city knew more about its senior citizens and their needs than before, but, in addition, based on the self-administered assessment of the elderly themselves, Iowa City committed itself eventually to development of a congregate facility for the elderly. In view of the constraints under which the study was conducted, any approach other than self-report would have been impossible (the cost constraint was $4,000, and the time constraint allowed 4 months for the formulation, distribution, statistical analysis, and preparation of the written report).

Conclusions and Recommendations

The purpose of this investigation was to examine the feasibility of obtaining multidimensional functional assessment information using a self-administered mode in contrast to the usual interview mode in order to simplify the assessment process. Objective scoring was a second step in the same direction. The evidence suggests that both are viable processes and make the process more readily available and economical. The only caveat which must be asserted is that these findings pertain to well elderly persons still living relatively independently. Whether and to what extent self-administered assessment may be useful among ill elderly living in or applicants for admission to long-term care institutions have yet to be determined. This kind of a study would be worth doing. Perhaps a more worthwhile and logical next step would be the development of a psychometrically constructed inventory that could be easily and quickly scored and would provide information basic to understanding the needs and status of both individuals and, for survey purposes, of members of large groups of elderly persons.

References

Duke University, Center for the Study of Aging and Human Development (1978). *Multidimensional functional assessment: The OARS methodology* (2nd ed.). Durham, NC: Author.

Fillenbaum, G.C., & Smyer, M.A. (1981) The development, validity, and reliability of the OARS Multidimensional Functional Assessment Questionnaire. *Journal of Gerontology*, 36, 428–434.

Fleiss, J. L. (1971). Measuring nominal scale agreement among many raters. *Psychological Bulletin*, 76, 378-382.

George, L.K., Landerman, R., & Fillenbaum, G.g. (1982). *Developing measures of functional status and service utilization: Refining and extending the OARS methodology*. Durham, NC: Duke University, Center for Aging and Human Development.

Holmes, T.H., & Rahe, R. H. (1967). The social adjustment scale. *Journal of Psychosomatic Research*, 11, 213-218.

Laurie, W.F. (1977). Report to the Congress on the well-being of older people in Cleveland, Ohio. Publication No. HRD 77-70: Washington, DC: U.S. General Accounting Office.

Lawton, P.L., Moss, M.S., Fulcomer, M. & Kleban, M.H. (1982). A research and service oriented multilevel assessment instrument. *Journal of Gerontology*, 37, 91-99.

Light, R. J. (1971). Measures of response agreement for qualitative data: Some generalizations and alternatives. *Psychological Bulletin*, 76, 365-377.

Munson, D. E. (1983). *Congregate housing: A study of local elderly needs*. Iowa City: The Iowa City, Iowa Housing Commission.

Slavonic, M.J. (1983, July). Assessment of the functional health status of the male geriatric veteran: Criterion validity of a mail-out questionnaire. Unpublished master's thesis. University of Nevada, Reno.

U.S. General Accounting Office (1980). Comparison of the well-being of older people in three rural and urban locations. Publication No. HRD 80-41. Washington, DC: Author.

The Gerontological Society of America Publications Committee announces an opening for the volunteer position of Editor in Chief of the *Journal of Gerontology* for a 4-year term commencing January 1, 1987. Individuals must be members of the Gerontological Society of America to be considered for this position. Nominations and applications, with curriculum vitae, must be submitted to the Gerontological Society of America Central Office no later than February 1, 1986. They should be addressed to:

Mrs. Betty Borgen
1411 K Street, N.W.
Washington, DC 20005

Table 24-1
The Social Readjustment Rating Scale

Life Event	Mean Value
Death of spouse	
Divorce	
Marital separation	
Jail term	
Death of close family member	
Personal injury or illness	
Marriage	
Fired at work	
Marital reconciliation	
Retirement	
Change in health of family member	
Pregnancy	
Sex difficulties	
Gain of new family member	
Business readjustment	
Change in financial state	
Death of close friend	
Change to different line of work	
Change in number of arguments with spouse	
Mortgage over $10,000	
Foreclosure of mortgage or loan	
Change in responsibilities at work	
Son or daughter leaving home	
Trouble with in-laws	
Outstanding personal achievement	
Wife beginning or stopping work	
Beginning or ending school	
Change in living conditions	
Revision of personal habits	
Trouble with boss	
Change in work hours or conditions	
Change in residence	
Change in schools	
Change in recreation	
Change in church activities	
Change in social activities	
Mortgage or loan less than $10,000	
Change in sleeping habits	
Change in number of family get-togethers	
Change in eating habits	
Vacation	
Christmas	
Minor violations of the law	

*Those events that are more frequent in the lives of elders.

BEST COPY AVAILABLE

Table 2-2
Characteristics of Selected Measures of Physical Health

Name of Measure (Reference)	*Items Included*	*Type of Scale*	*Administration*	*Reliability*	*Validity*
Cornell Medical Index (Brodman et al. 1951)	195 items in 12 categories of physical health and 51 items in 6 categories of mental health.	Yes-no answers; each answer reflecting a health symptom, problem, or concern gets a points. In community-based sample of elders, mean score of 16.2 for men and 22.2 for women.	Self-completed by subjects. Takes about 20 minutes.		
Cumulative Illness Rating Scale (Linn, Linn, and Gurel 1968)	13 organ systems: heart, vascular; respiratory; EENT; upper GI; lower GI; hepatic; renal; other GU; musculoskeletal; neurologic; psychiatric; endocrine-metabolic.	Each organ system scored on 5-point scale for severity of impairment (none to extremely severe); subscores are derived for impairment on 5 systems—for example, cardiovascular or gastrointestinal.	Physician ratings with brief instructions.	Interrater reliability ranges from .91 to .83 on various sets of ratings.	Review of 472 health histories showed that cumulative-impairment scores predict death better than chronological age.
Health Index (Rosencranz and Pihlblad 1970)	40 common ailments listed and subject asked about duration of problem; also asked about illnesses that have confined them to bed, to house, or to hospital in past month.	4 points for each major illness and 4 more for each that confined patient in past month; 2 points for each minor illness and 2 for confining patient; added points for severity and duration of confinement.	Administered to subject by interviewer.		5 classes developed on basis of scores; these correlate well with self-perceptions of health and functional-status indicators.
PACE II: Medical Data (U.S. DHEW 1978a)	Checklist of 22 diagnostic categories and medical-status measures including height, weight, blood pressure, pulse, respiration, 4 blood tests, 3 urine tests, stool test.	No score derived.	Review of history; conduct of physical examination and tests.		
Patient Classification for LTC: Impairments and Medical Status (Jones, McNitt, and McKnight 1974)	Impairments = sight, hearing, speech, fractures, joint motion, missing limbs, paralysis and dentation; risk factors = height, weight, blood pressure, BUN, blood cholesterol, albuminurea, and smoking; 14 medically defined conditions listed.	3-point classification for impairments with checklist for ways of compensating; all others checklist; no score derived.	Physician or nurse giving care completes items.		
OARS: Physical Health (Duke University 1978)	Doctor visits, sick days, hospital days, nursing-home days; 18 categories of medications; 26 illnesses; disabilities; vision; hearing; prostheses used; drinking; exercise; self-	Some Likert scales; medications, illnesses and prostheses on checklists; overall physical health scored as 1-6, ranging from excellent physical health to totally physi-	Interview with subject.	See Chapter 5	

490

Table 2–4
Katz Index of ADL

Index of Independence in Activities of Daily Living

The Index of Independence in Activities of Daily Living is based on an evaluation of the functional independence or dependence of patients in bathing, dressing, going to the toilet, transferring, continence, and feeding. Specific definitions of functional independence and dependence appear below the index.

A	Independent in feeding, continence, transferring, going to toilet, dressing, and bathing.
B	Independent in all but one of these functions.
C	Independent in all but bathing and one additional function.
D	Independent in all but bathing, dressing, and one additional function.
E	Independent in all but bathing, dressing, going to toilet, and one additional function.
F	Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
G	Dependent in all six functions.
Other	Dependent in at least two functions, but not classifiable as C, D, E, or F.

Independence means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status and not on ability. A patient who refuses to perform a function is considered as not performing the function, even though he is deemed able.

BATHING (Sponge, shower or Tub)
Independent: assistance only in bathing a single part (as back or disabled extremity) or bathes self completely
Dependent: assistance in bathing more than one part of body; assistance in getting in or out of tub or does not bathe self

DRESSING
Independent: gets clothes from closets and drawers; puts on clothes, outer garments, braces; manages fasteners; act of tying shoes is excluded
Dependent: does not dress self or remains partly undressed

GOING TO TOILET
Independent: gets to toilet; gets on and off toilet; arranges clothes, cleans organs of excretion; (may manage own bedpan used at night only and may or may not be using mechanical supports)
Dependent: uses bedpan or commode or receives assistance in getting to and using toilet

TRANSFER
Independent: moves in and out of bed independently and moves in and out of chair independently (may or may not be using mechanical supports)
Dependent: assistance in moving in or out of bed and/or chair; does not perform one or more transfers

CONTINENCE
Independent: urination and defecation entirely self-controlled
Dependent: partial or total incontinence in urination or defecation partial or total control by enemas, catheters, or regulated use of urinals and/or bedpans

FEEDING
Independent: gets food from plate or its equivalent into mouth; (precutting of meat and preparation of food, as buttering bread, are excluded from evaluation).
Dependent: assistance in act of feeding (see above); does not eat at all or parenteral feeding.

Table 2–4 (continued)

Evaluation Form

Name ____________________ Date of Evaluation __________

For each area of functioning listed below, check description that applies. (The word *assistance* means supervision, direction of personal assistance.)

BATHING—either sponge bath, tub bath, or shower

☐	☐	☐
Receives no assistance (gets in and out of tub by self if tub is usual means of bathing)	Receives assistance in bathing only one part of body (such as back or a leg)	Receives assistance in bathing more than one part of body (or not bathed)

DRESSING—gets clothes from closets and drawers—including underclothes, outer garments and using fasteners (including braces, if worn)

☐	☐	☐
Gets clothes and gets completely dressed without assistance	Gets clothes and gets dressed without assistance except for assistance in tying shoes	Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed

TOILETING—going to the "toilet room" for bowel and urine elimination; cleaning self after elimination and arranging clothes

☐	☐	☐
Goes to "toilet room," cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning)	Receives assistance in going to "toilet room" or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode	Doesn't go to room termed "toilet" for the elimination process

TRANSFER—

☐	☐	☐
Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)	Moves in or out of bed or chair with assistance	Doesn't get out of bed.

CONTINENCE—

☐	☐	☐
Controls urination and bowel movement completely by self	Has occasional "accidents"	Supervision helps keep urine or bowel control; catheter is used or is incontinent

FEEDING—

☐	☐	☐
Feeds self without assistance	Feeds self except for getting	Receives assistance in feed-

On each item the individual is given points for being able to perform it independently and fewer points for performance with help. The score values are weighted and may be 15, 10, 5, or 0. For example, 10 points are given for independent feeding and 5 points for requiring help (including cutting of food), whereas 15 points are given for independent ambulation and 10 for ambulation with help. On two items (bathing and going to the toilet) full independence earns only 5 points and requirements for some help receive 0 points. The highest possible Barthel score of 100 signifies independence on all items, although the originators of the instrument make clear that this does not mean the subject could live alone without social assistance. (He might need help, for example, with cooking or cleaning). The Barthel score reflects ability to perform ADL activities without a personal care attendant. In rehabilitation settings, the Barthel Index correlates well with clinical judgment and has been shown to predict mortality (Wylie 1967) and ability to be discharged to less-restrictive settings (Granger and Greer 1976).

Granger adapted the Barthel Index into a series of ordinal scales (Sherwood et al. 1977). The resulting instrument is called the Barthel Self-Care Ratings. Some additional items have been added to the original group and each is rated on a four-point scale of intact/limited/helper required/null. An

Table 2-5
Barthel Index

Activities Rated by Examiner	*Points for Performance*[a]	
	Independently	*With Help*
1. Feeding (if food needs to be cut = help)	10	5
2. Moving from wheelchair to bed (includes sitting up in bed)	15	10-5
3. Personal toilet (wash face, comb hair, shave, clean teeth)	5	0
4. Getting on and off toilet (handling clothes, wipe, flush)	10	5
5. Bathing self	5	0
6. Walking on level surface	15	10
Propel wheelchair (score only if unable to walk)	5	0
7. Ascend and descend stairs	10	5
8. Dressing (includes tying shoes, fastening fasteners)	10	5
9. Controlling bowels	10	5
10. Controlling bladder	10	5

Source: Extrapolated from F.I. Mahoney and D.W. Barthel, "Functional Evaluation: The Barthel Index," *Maryland State Medical Journal* 14 (1965):61-65.

[a] Total possible points = 100

Table 2-7

Characteristics of Selected Measures of Ability to Perform Instrumental Activities of Daily Living

Name of Measure (Reference)	*Items Included*	*Type of Scale*	*Administration*	*Reliability*	*Validity*
Functional Health Status (Rosow and Breslau 1966)	Doing heavy work (such as snow shoveling); no physical illness or condition *now*; not limited in any activities; able to walk half a mile; climb stairs; go out to a movie or meeting.	6 items listed from Guttman scale in order of increasing difficulty.	Short instrument with 25 questions administered to subject; items making Guttman scale imbedded in questionnaire.	Reproducibility coefficient = .91; test-retest reliability not reported.	Not reported: ity of self-repo assumed from studies.
PGC Instrumental Activities of Daily Living (Lawton 1972)	Using telephone; shopping; food preparation; housekeeping; laundry; public transportation; taking medications; handling finances.	Most items on 3-point scale; no instructions on summing items; effort to create a Guttman scale.	Observer ratings.	Reproducibility coefficient = .94; interrater reliability not reported.	Investigator co ments that mea does not tap fu content of IAD is more suitabl women.
Instrumental Role Maintenance Scale (Lawton 1972)	Frequency of meal preparation other than breakfast; frequency of shopping; distance of shopping from residence; manner of doing laundry.	Guttman scale.	Self-report questionnaire to use with women who apply for nursing-home admissio	Reproducibility coefficient = .94; test-retest reliability not reported.	Investigator co ments that mea does not tap fu content of IAD and is more sui for women.
PACE II: IADLs (U.S. DHEW 1978a)	Using telephone; handling money; securing personal items; tidying up; preparing meals.	No problem; performs with human help (indicate how many helpers); or does not perform; no instructions on summing.	Completed by staff of institution or by appraiser.		Possibility that items will be pr hibited by nursi home policy.
OARS: Instrumental ADL (Duke University 1978)	Using telephone; shopping for groceries or clothes; transport self to places out of walking distance; prepare meals; do housework; take medicine; handle own money.	Each item rated as: without help, with help, or unable to perform; a global score of ADL and IADL made on 6 points, ranging from excellent to completely impaired.	Interview with subject.	See chapter 5	
Functioning for Independent Living (Gross-Andrew and Zimmer 1978)	Vision; hearing and speech; mobility; bowel and bladder control; confused behavior; knowledge of identity; ability to make self understood; wandering; extent of nonconventional behavior.	Choices within items are keyed to tasks relevant to independent living (for example, sees well enough to recognize household objects but not to cross streets); items weighted; total possible score of 47 reflects maximum disability.	Professional ratings based on observation and asking client or family member.		
Performance Activities of Daily Living (PADL) (Kuriansky and Gurland 1976)	16 activities: drink from cup; wipe nose; comb hair; file nails; shave; eat with spoon; turn faucet on and off; turn light switch on and off; take jacket with buttons on and off; put on and remove slippers; brush teeth (real or false); make telephone call; sign name; turn key in lock; tell time; stand up and walk and sit down.	Tasks are rated as 0 (performed without help) or 1 (unable to perform without help). A 9 indicated task did not apply or wasn't requested. No allowance made for disability, lack of cooperation, or lack of comprehension.	Tests administered with props; subject performs each task in order of difficulty; paraprofessional can administer.	Interviewer and observer reliabilities were high (.9) in a pilot study.	Predictive validity claimed in terms disposition and mortality.

BEST COPY AVAILABLE

TABLE 2-7 (Cont)

Pilot Geriatric Arthritis Project Functional Status Measure (PGAP) (Deniston and Jette 1980)	12 mobility items (driving, shopping, walking inside, walking outside, stairs into home, other stairs, curbs, transfer bed, transfer chair, transfer car, transfer toilet, transfer bath): 17 personal care items (telephone; writing; cutting food; drinking; washing self; turning faucets; teeth care; shaving; combing hair; setting hair; donning shoes, hose/pants, underclothes, shirt/blouse; buttoning/zipping sweater/coat): 15 work items (employment; stove/oven/refrigerator; sink/faucets; reading; cupboards; lifting pots; peeling/cutting; opening containers; laundry; sweeping/mopping; making beds; washing dishes; cleaning bathroom; washing windows/home repair; yardwork.	For each of 44 items, 3 ratings are made: a dependency rating (0 = independent, 1 = mechanical help, 2 = human help, 3 = both kinds of help, 4 = cannot perform); a pain rating (1 = no pain, 2 = mild, 3 = moderate, 4 = severe); and a difficulty rating (same scale as pain rating). Scores are summed and 2 subscores are created for mobility, personal care, and work.	Rating on basis of patient self-report.	Repeated measures of same person by different interviewers produced same score 85 percent of time; interrater reliability best with dependency items and worst with difficulty items; reliability best at lowest level of functional ability and worst for midpoints of scales.	Scores correlated with clients' ratings of (1) their joint status and (2) their ability to deal with their arthritis and associated problems. Scores did *not* correlate with professional ratings of their clients' joint status or ability to deal with their arthritis.

Table 2-8
Selected Measures of Physical Functioning by User, Purpose, and Recommendations

Measure	*User*[a]	*Purpose*[b]	*Recommendations*
Cornell Medical Index	n, r	d, s	Not recommended
Health Index	r	d, a, m	Promising self-report on health
PACE II and Patient Classification Form (relevant sections)	g	d, a	Record-keeping system only
OARS (relevant sections)	n, g, c, r	d, a	Community-based assessment when observation is unpractical
Cumulative Illness Rating Scale	n, g	d, a, p	Not recommended
PULSES	g, c	d, a, p	Not recommended
Katz Index of ADL	n, g	d, a, m, p	Useful general tool
Barthel Index	n, g	d, a, m, p	Useful when sensitive tool needed
Disability Rating Scale	n, r	d, p	Not recommended
Kenny Self-Care Evaluation[c]	g	d, a, m, p	Useful in rehabilitation settings
Granger Range of Motion	n, g	d, a, m	Useful in rehabilitation settings
Rosow Functional Health Scale	r	d	For group information only
PGC IADL	g, c	d, s, a	Promising tool, best for women
PGC Instrumental Role Maintenance	g, c	d, s, a	Promising tool, best for women
Caro Functioning for Independent Living Scale	c	d, s	Promising tool, practical
Performance ADL	n, g, c	d, m, a, p	Promising tool, depends on demonstration
PGAP Functional Assessment Instrument	g, [illegible]	d, m, a,	Promising tool, offers added dimensions of ADL and IADL

[a] User: n = nongeriatric provider; g = geriatric provider; c = case manager; r = researcher.

[b] Purpose: d = description; s = screening; a = assessment; m = monitoring; p = prognosis.

[c] As refined by H.A. Schoening, L. Anderegg, D. Bergstrom, M. Fonda, N. Steinke, and P. Ulrich, "Numerical Scoring of Self-Care Status of Patients," *Archives of Physical Medicine and Rehabilitation* 46 (1965):689–697.

The determination of potential users of an instrument depends to some extent on the amount of detail it is capable of generating. Some instruments (Katz ADL, Granger Range of Motion) are useful for both the geriatric specialist and the nonspecialist provider. (The former might use the measure as a first-line screen prior to more detailed studies, whereas the latter could use it as a quick check on the overall status of the patient.)

BEST COPY AVAILABLE

BLANK PAGE

In this class, your task as the instructor is to integrate what has been presented in previous chapters and present to the students a more comprehensive view of the assessment process.

Review the various definitions of the word "normal" with students. Ask them to list the various methods of establishing normalcy.

Using the text, review and discuss standard deviation and its uses. Emphasize to students that most assessments are not normed for the elderly. Discuss with students factors that must be taken into consideration when testing the mental/intellectual capabilities of older clients. Some of these are: 1) the possibility that depression is causing the client to appear demented, 2) physical changes related to the aging process, 3) level of acquired education (and what that consisted of), 4) chronic illnesses, and 5) current environmental factors (i.e., too cold a room, etc.).

Discuss deinstitutionalization. Does this policy affect your students' work? Another point for discussion is social acceptance. This is presented in the text in such a manner as to foster group discussion. Ask the students to discuss some of the changing standards of social acceptability that they have seen in their lives.

Review the models of aging with the students briefly. Discuss the terms "endogenous" and "exogenous." Endogenous problems stem from within and exogenous ones originate outside of the individual. What are some endogenous problems that can disrupt the life of an older person?...Exogenous ones?

Go over the section in the text on the polyproblemed client, discussing the author's distinction between polyproblemed clients and multiproblemed clients. Does this distinction seem clear to the students?

Discuss placement problems that arise in your area for polyproblemed clients.

ASSESSMENT: THE POLYPROBLEMED CLIENT AND PLACEMENT

Name: ______________________________ **Date:** __________________

CIRCLE THE CORRECT ANSWER.

1. Endogenous problems are those which:

   a. originate externally or in the environment
   b. originate internally or from within the individual
   c. can be overcome with proper treatment

2. A polyproblemed client is defined as:

   a. one who is over 85 years old
   b. one who is experiencing physical problems
   c. one who presents more than one problem at a time

3. Among health and human service agencies, the most common form of polyproblemed client is:

   a. the "dually diagnosed" (having two problems)
   b. the polypharmacy client
   c. the suicidal client

4. Which of the following is not one of the keys to sound mental health?

   a. maintenance of memory processes
   b. positive attitude and acceptance of self
   c. reality perception and adjustment

5. When the inability to cope with one particular stressful event leads to an every increasing number of serious symptoms, there is ____________________.

   a. problem proliferation
   b. pseudodementia
   c. true dementia

6. The type of norm which is based on the population average and standard deviation is the

   a. social norm
   b. absolute norm
   c. statistical norm

7. One of the problems with absolute norms is that they:

   a. are based on the premise "if it works, it must be all right."
   b. are used only in dictatorships
   c. are subject to arbitrary interpretation and administration

8. One problem with using social norms to assess the elderly is that:

    a. they have no social support system
    b. social norms change with time
    c. the use of social norms is not practical

9. The assessment process of client placement is best approached as:

    a. a way to decrease the number of institutionalized elderly
    b. an individual matching process between client and environment
    c. a grouping process

10. In order for statistical norms to be useful:

    a. norms must exist for the particular assessment and population
    b. the average must be 100 and the standard deviation must be 15
    c. no one must fall more than 2 standard deviations away from the average

Assessment: The Polyproblemed Client and Placement

1. b
2. c
3. b
4. a
5. a
6. c
7. c
8. b
9. b
10. a